Centers for Medicare & Medicaid Services
Special Open Door Forum:
Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy
Tuesday, February 3, 2015
1:30-2:30 pm Eastern Time
Moderator: Jill Darling

Operator: Good afternoon, my name is Michelle, and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Prior Authorization Non-Emergent Hyperbaric Oxygen Therapy Special Open Door Forum.

All lines had been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I would now like to turn the call over to Ms. Jill Darling; you may begin your conference.

Jill Darling: Thank you Michelle. Good morning and good afternoon everyone. My name is Jill Darling in the CMS Office of Communications and welcome to today's Special Open Door Forum.

I will just – we'll get right into it and hand the call over to Connie Leonard, she's the Provider Compliance Group Deputy Director.

Connie Leonard: Thank you Jill. Thank you everyone for joining us today. We're having our third call on the prior authorization of non-emergent hyperbaric oxygen therapy. And we heard a lot of comments from you in the first two calls and we hope we're going to be able to adjust some changes we made based on the comments we received on the calls and in our e-mailbox.

So, we'll go to our slide presentation, I'll try to highlight those changes and then we will (obviously) have a Q&A session to get some additional feedback and comments from you. And with that, I'll turn it over to Jennifer.

Jennifer: Thank you Connie. The purpose of this model is to establish a three-year prior authorization process for non-emergent hyperbaric oxygen (HBO) therapy, and to reduce expenditures and minimize the risk of improper payments while beneficiaries continue to receive medically necessary care, in order to protect the Medicare Trust Fund by granting provisional affirmation for a service prior to submission of the claim.

Prior authorization is a process through which a request for provisional affirmation of coverage is submitted for a review before a service is rendered to the beneficiary and before a claim is submitted for payment. Prior authorization helps confirm that applicable coverage, payment and coding rules are met before services are rendered. Some insurance company such as TRICARE, certain Medicaid programs and the private sector already use prior authorization to ensure proper payment before the service is rendered.

HBO therapy is the modality in which the entire body is exposed to oxygen under increased atmospheric pressure. The National Coverage Determination (NCD) can be found in the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.29.

Of the 15 covered medical condition listed in the NCD, 6 will be available for prior authorization. The six conditions available for prior authorization are: Preparation and preservation of compromised skin grafts (not for primary management of wounds); Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management; Osteoradionecrosis as an adjunct to conventional treatment; Soft tissue radionecrosis as an adjunct to conventional treatment; Actinomycrosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment; And diabetic wounds of the lower extremities in patients who meet the following three criteria: The patient has Type I or Type II diabetes and has a lower extremity wound that is due to diabetes, the patient has a wound

classified as Wagner grade III or higher, and a patient has failed an adequate course of wound therapy as defined in the NCD.

Facilities who submit HBO claims with bill type 13 hospital outpatient for beneficiaries under traditional Medicare coverage are included in this model when they are in the states of Illinois serviced by MAC J6 NGS, Michigan serviced by MAC J8 WPS or New Jersey serviced by MAC JL Novitas.

The MACs will begin accepting prior authorization requests on March 1, 2015 for HBO treatments with one of the 6 included conditions occurring on or after April 13, 2015. All HBO treatments with one of the six included conditions and a date of service on or after April 13, 2015 must have completed the prior authorization process or the claims will be stopped for prepayment review.

The following HBO HCPCS code is subject to prior authorization: G0277, hyperbaric oxygen under pressure, full body chamber, per 30 minute interval. This HCPCS replaced C1300 on January 1, 2015. Prior authorization is only needed for the facility payment part of the HBO therapy service. Physicians do not need to request prior authorization.

However, if a facility does not have prior authorization or has a non-affirmed prior authorization, the associated physician claims with the following code will be subject to medical review – 99183, physician attendance and supervision of hyperbaric oxygen per session.

Medicare coverage policies, documentation requirements, and time frames for HBO therapy are not changing. The model does NOT create any new documentation requirements. It simply requires the information be submitted earlier in the process. Current requirements can be found on the A/B MAC Web sites.

The NCD can be found in the Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.29. HBO therapy is covered as adjunctive therapy only after there are no measurable signs of healing for at least 30 days of treatment with standard wound therapy and must be used in addition to standard wound care. Failure to respond to standard wound care

occurs when there are no measurable signs of healing for at least 30 consecutive days. Wounds must be evaluated at least every 30 days during administration of HBO therapy. Continued treatment of HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment.

Also unchanged are that the A/B MACs will conduct the reviews, all Advanced Beneficiary Notice (ABN) policies and claim appeal rights. What have changed? The facility will know earlier in the beneficiary's course of treatment whether Medicare will pay for the service. Upon request, the beneficiary will be notified earlier in his or her course of treatment whether Medicare will pay for the service.

As of January 29, 2015, the prior authorization request needs to identify: the beneficiary's name, Medicare Number, date of birth and gender; the physician's name, National Provider Identifier (NPI) and address; the facilities name, NPI and address; the requestor's name and telephone number; the procedure code; submission date; start of the 12-month period; number of treatments requested; diagnosis codes; indicate if the request is an initial or resubmission review; and indicate if the request is expedited and the reason why.

The request also needs to include documentation from the medical record to support the medical necessity. And any other relevant document as deemed necessary by the contractor to process the prior authorization, such as: documentation supporting date of skin graft and compromised state of graft site; history and physical; prior medical, surgical and/or previous HBO therapy; prior antibiotic therapy and surgical interventions or any adjunctive treatment currently being rendered; procedure logs including ascent time, descent time, and pressurization level; lab results, culture or gram stains, confirming the diagnosis of actinomycosis; X-Ray findings and/or bone cultures confirming the diagnosis of chronic refractory osteomyelitis and what forms of medical/surgical management was tried and failed; legible signed physician order for the services billed.

It is important to note that this is not an all-inclusive list. Please check with your MAC for complete documentation requirements. I will now turn things over to Angela Gaston to continue the presentation.

Angela Gaston: Thank you Jennifer. A provisional affirmative prior authorization decision may affirm up to 40 courses of treatment in a 12 month period. If additional sessions are needed in excess of the 40 treatments, a new prior authorization request may be submitted.

The facility or the beneficiary may submit the prior authorization request. It can be mailed, faxed, submitted through esMD system or submitted through the MAC's provider portal where available.

Request time frame. Prior authorization should be requested as soon as the HBO treatment is scheduled. Treatment should not be delayed due to a pending prior authorization decision. An affirmed decision will retroactively apply to the start date requested on the prior authorization request. Claims should not be submitted until the prior authorization decision has been received.

Review time frames. For the initial requests, the MAC makes every effort to review the request and postmark decision letters within 10 business days. Resubmitted requests are requests resubmitted with additional documentation after the initial prior authorization request was not affirmed. The MAC makes every effort to review these requests and postmark decision letters within 20 business days. Expedited circumstances are when the standard time frame could jeopardize the life or health of the beneficiary. The MAC will make reasonable efforts to communicate a decision within two business days.

Decision letters are sent to the facility and to the beneficiary, upon request. Decision letters that do not affirm the prior authorization request will provide a detailed written explanation outlining which specific policy requirement was not met.

When a prior authorization request is submitted but not affirmed, a submitter can resolve the non-affirmative reasons described in the decision letter and resubmit the prior authorization request. Unlimited resubmissions are allowed.

However, prior authorization request decisions are not appealable. Or a submitter can provide the service and submit the claim. The claim will be denied; however, at that point, all appeal rights will be available.

The MACs will list the prior authorization unique tracking number on the decision letter. The tracking number must be submitted on the facility claim but the physician Part B claims do not need a tracking number. When submitting an electronic 837 institutional claim, the unique tracking number should be submitted at the 2300 Claim Information level in the Prior Authorization reference segment where REF01 equals "G1" qualifier and REF02 equals UTN.

When submitting a paper CMS 1450 Claim form, the unique tracking number should be submitted in Form Locator 63. The UTN should be submitted on the same line (A, B, C) that Medicare is shown in Form Locator 50 (Payer Line A, B, C). The UTN should begin in position 1 of Form Locator 63.

If a facility has not requested prior authorization, the subsequent claims will be stopped for prepayment review. The MAC will send an additional request letter and wait the 45 days for a response. The MAC will then review submitted documentation within 60 days. Without a prior authorization decision, the facility or the beneficiary will not know whether Medicare will pay for the service and the facility or beneficiary may be financially liable. CMS strongly encourages providers to use the Medicare prior authorization process.

This next slide summarizes the different scenarios that could occur. Scenario 1, the prior authorization request is submitted, the MAC decision is affirmative. The facility chooses to render the service and submit a claim. The MAC will pay the claim as long as all other requirements are met.

Scenario 2, the prior authorization request is submitted but the MAC decision is not affirmative. The facility could either A) submit the claim, the MAC will then deny the claim or B) the facility can fix and resubmit the prior authorization request.

Scenario 3, the prior authorization request is not submitted; therefore, there is no MAC decision. The facility can choose to render the service and submit a claim. The MAC will then stop that claim for prepayment review. Please note that if a facility has no prior authorization or a non-affirmed prior authorization, the associated physician claim will be subject to medical review.

As for the beneficiary impact, the service benefit is not changing. Beneficiaries, upon request, will receive a notification of the decision about their prior authorization request. Dual eligible coverage is not changing and private insurance coverage is not changing.

The MACs have additional information on HBO services on their Web sites. Illinois is in Jurisdiction J6, NGS. Michigan is Jurisdiction J8, WPS and New Jersey is Jurisdiction J11, Novitas.

You can find additional information on the CMS HBO Prior Authorization Model Web Site. The address is http://go.cms.gov/PcapitalAHBO. There you will find a fact sheet, frequently asked questions, background information, information on open door forums and coming soon will be an operational guide.

So in summary, the prior authorization model begins on March 1, 2015 in the states of Illinois, Michigan and New Jersey. Requests can be submitted by the facility or the beneficiary and it will last for three years.

For more information, you can also e-mail the prior authorization team at HBOPA@cms.hhs.gov and now I'll turn it back to Connie Leonard for additional information.

Connie Leonard: Thank you Angela. So for those of you that attended one of the first two open door forum, you may have heard some significant changes. The slide presentation if it's not already up on the Web site, it should be live up some time during this afternoon. And on page 7, we talked about a date of service start date change.

When the model begins on March 1st, the documentation can be submitted for claims for date of service of April 13, 2015. That gives an additional six

weeks of time for facilities and the MAC to work together to make sure the facilities know what documentation needs to be submitted.

We'd like to see this time period - because we do understand that as of March 1st there's probably not going to be a significant number of patients that may still be getting HBO treatment as of mid-April, but we'd like to see the early part of that time period being used to have conversations with the MAC about particular cases you can ensure you're going to get, to be able to send in the appropriate documentation.

We are looking for volunteers that are going to be affected by the model, so only for (inaudible) in Illinois, Michigan and New Jersey that would be willing to work with the MAC this first few weeks to ensure that they will be able to submit the appropriate information come late March or early April when they're ready to submit that entire package for a date of service of April 13 or beyond.

If you would like to volunteer to work with your MAC during those few first weeks to ensure that you know exactly what documentation needs to be submitted, please e-mail, the e-mail address box, so we can work with you to work out the details. Again, the e-mailbox is HBOPA@cms.hhs.gov.

The other big change and this is something that you suggested in both of our previous calls was the number of treatment. The number of treatment previously was 36 and several of you voiced from the call and in comments to our mailbox that a better number was 40.

That, 40 was the number of treatments that you could see in the majority of requests. Sometimes you would only need the 40 seen just in the one request, meaning there would not be a need to submit a second request. And so you guys were wonderful at submitting supporting documentation with your comments and we took a look – we took a look at a lot of the documentation and we agree to change to 40, so the number of treatments has increased from 36 to 40.

The last big change dealt with how the approval process was going to work, specifically for diabetic wounds of the lower extremities or some of these

other type of condition that require a 30-day of standard care before even going into the HBO therapy. And in working with various associations, to working amongst the clinicians here at CMS, we decided the best approach for us is to have a retroactive approval process. Meaning, that we want you to begin therapy as soon as it is necessary, following the NCD Guidelines.

What we don't want to have is to create duplicate work on your part or the MAC's part in approving multiple prior authorization requests for the same time span. So, what we're saying is that on May 1st, you begin treatment and you also on May 1st or May 2nd, go ahead and submit that prior authorization request. On your cover sheet, you're going to put down the date of May 1st until you think it's going to end, how many treatments is appropriate. And then once that decision is affirmed, it will go back until May 1st. It won't start with May 7th, or May 9th or whatever date the actual affirmed date. It will go backward.

As Angela stated in the slide presentation, it will be very important that you not submit claims while the request is getting reviewed because those claims without a UTN will stop for prepayment review. Once you had that affirmed UTN number, you can go ahead and fix your claim and they will process through for payment.

So, that was a big change that we think is the best of both worlds. It still allows the prior authorization process to continue while ensuring that there's going to be no access to care issue. And that can be found on page 17, if anyone is looking from a slide perspective. On page 15, that's where we talked about the number of treatment change.

Slide 13 and slide 14 included some requirements, the documentation requirements that come in with the prior authorization request. Slide 13 is basically your – the initial basic information for the beneficiary in the prior authorization request. There will be a cover sheet or a voluntary form that's going to be up there on the MAC Web site for you to use to submit.

Slide 14 goes into some more detail on the types of information that the MACs can be looking for in the actual medical record and prior authorization

package. We wanted to get those out to you early and we want to hear your questions on documentation. We expect that when you go to the educational session for the MAC will be conducting, the documentation will be explained and will be a much anticipated discussion topic between the MAC and the facilities who attend.

The MAC is really the best point for documentation-type questions. You certainly can facilitate discussions and we are actually working on having discussions with associations and MAC and again getting the feedback, so everyone knows exactly what's going to be needed for their jurisdiction.

In page 25, just to reiterate, includes the MACs that are included in these three states and also different links to the MAC Web Sites. So those MAC Web Sites, they're going to be where to find information out about the MAC educational sessions they're hosting and they will be posting them this month. A lot of them will be webinars, so they will be easily accessible by all, but they're also good locations to have when the forms go out, that's for the cover sheet, so the forms will be available there.

They will have frequently asked questions and other important information for facilities. So, it's a – it's a good thing to check in if there's a Listserv availability for your MAC. To kind of get in the Listserv, just to make sure you're going to be aware of any of these educational sessions or these updates that is put out there.

And as Angela mentioned the CMS Web Site we'll have an operation guide out there soon that you will be able to, again, just use to assist you in submitting the prior authorization request. And with that, I would like to turn it open for questions and comments.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your question to one question and one follow-up to allow other participants time for questions. If you require any follow-up questions, you may press one again to rejoin the queue.

Your first question comes from (Jackie Chinnen) from Covenant HealthCare, your line is open.

(Jackie Chinnen): Hi, yes, can you please tell me, the patients that we are currently treating, what is the process for those patients if they do go into this new process this period of time, what do we do with those patients?

Connie Leonard: If they're still going to be getting a hyperbaric oxygen therapy on April 13th, then you will need to submit a prior authorization request for that. And that's another great reason as to why we have this six-week window. We do realize as we get closer to the end of March, early April, there are going to be beneficiaries who are already getting services.

And so it would be ideal if facilities would submit those early, get those approved, so that once we begin the April 13, the MAC won't have to deal with all the older cases plus all of the new cases. So, it would be very beneficial if you have a beneficiary on March 1st or March 15 or whatever day it is that you know is still going to be getting therapy or you believe is still going to be getting therapy on April 13 to go ahead and submit that prior authorization package.

(Jackie Chinnen): OK, thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from (Kathleen Cham), Smith & Nephew, your line is open.

(Kathleen Cham): Yes, I heard you say that you're going to post the slides a little later but it's interesting because when I go on to the Web site and it has today's date and there is – there is a document, it's a document but there are no slides.

Connie Leonard: You're correct; the slides will be posted later today. That just may be one of the process is, that it is a two-set process for it to go live on the web or it's also possible that it just didn't go up and we'll need to put it up later this afternoon but the slides will be updated there. It is a – it is a document with slide that says February 3, 2015. There are probably previous slides on the

Web site but obviously those do not include our big changes. So, there will be a slide presentation there. We'll double check after the call and if we need to go in and put it up again, we'll certainly put it up. We do want to get these out to everybody.

(Kathleen Cham): OK, thank you.

Connie Leonard: Thank you for letting us know.

Operator: Your next question comes from (Becky Wovington) from McLaren, your line is open.

(Becky Wovington): Hi, we used our nurse practitioner to supervise our HBO for our day to day operation. Is that who we would list in our prior auth. request or do we list the supervising physicians?

Connie Leonard: Thank you, that's a great question and I want to get you a follow-up answer, just so I can make sure I provide you with an accurate answer. Could you e-mail into the e-mailbox?

(Becky Wovington): Yes, I sure can.

Connie Leonard: We can also do this frequently asked question on that just to make sure we give you the right answer for your nurse practitioner.

(Becky Wovington): Yes, that would be great.

Connie Leonard: Thank you.

(Becky Wovington): And then my – OK.

Operator: Your next question comes from (Iris Daniel) from Hyperbaric Medical, your line is open.

(Iris Daniel): Hi, my question is you say you require prior authorization or face the risk of coding which is facility and our place of service, the independent doctor's office, so we don't require any authorization for these services?

Connie Leonard: That is correct if you are providing the therapy in the physician's office setting; that is not part of this model.

(Iris Daniel): All right, thank you.

Connie Leonard: Thank you.

(Iris Daniel): OK. And do I still bill both for 30 minutes along with the 99183 code?

Connie Leonard: Yes, you follow the same billing practice that you would use today and those claims are not included in the model and they will not be chosen for review under the model.

(Iris Daniel): All right, thank you very much.

Connie Leonard: Yes.

Operator: Your next question comes from (Esther Charina) from Swedish Covenant Hospital, your line is open.

(Esther Charina): Hi, my question is regarding the codes. This is a facility, a hospital facility, the G0277 is a 30-minute increment and then you spoke about the 99183. Now in the December 10th handouts that they gave us, they said the 99183 was for the physician attendance for the physician office prior authorization (exist).

However if a facility does not have prior authorization or has a non-affirmed prior authorization the associated physician claims with the following code will be subject to the medical review, 99183. How does the hospital site billed for that? Because you're talking about the physician claims. We are billing the technical side for the HBO with the G0277 per 30-minute intervals.

Connie Leonard: So …

(Esther Charina): So, I'm confused as to the coding you want to see. The 99183 is 90 minutes.

Connie Leonard: The 99183 is only for the physician who's billing the treatment. The G0277 is for the facility code. In this model, it's only the outpatient therapy. It does not include any inpatient therapy …

(Esther Charina): Correct.

Connie Leonard: … only the facility, the billing requirements or the coding requirement haven't changed at all. You're going to bill the same way that you're billing today for the 30-minute increment in the G0277. So if it was a two-hour therapy session, you would go for four of those codes just like you would today.

The only reason we include the physician code in our package is because if the facility does not get the prior authorization request that they billed for that beneficiary and then a physician code claim comes in for that same beneficiary on those same dates, that physician code is the one that's going to be subject to review as well as when the G0277 claim comes in without a UTN is going to get stop for prepayment review. Those are the only ones that's going to get required on the post payment review. If a physician is doing it at his location, then they're not included in the model.

(Esther Charina): OK so …

Connie Leonard: But it's the same (inaudible) rules of today.

(Esther Charina): OK, but the physician will bill a 99183 not the hospital site?

Connie Leonard: Correct, yes.

(Esther Charina): OK so we just bill G0277 with no prior authorization or non-confirmed prior authorization.

Connie Leonard: If you bill the G0277 without a UTN number that claim is going to get stopped for prepayment review.

(Esther Charina): So then there really isn't on the hospital facility site any billing without a prior authorization?

Connie Leonard: That is correct outside of inpatient. Any outpatient facility that's exactly what's included in this demonstration in this …

(Esther Charina): OK.

Connie Leonard: … model. It has …

(Esther Charina): Yes, OK, I wanted - I wanted to clarify that because it was confusing with the 99183.

Female: Yes, yes.

Connie Leonard: All facility claims require a UTN number. You got it.

(Esther Charina): OK.

Connie Leonard: Thank you.

Operator: Your next question comes from (Gina Treadwell) from Berkeley Medical. Your line is open.

(Gina Treadwell): My question has to do with how this is going to be - the information is going to be published. Will we be able to see results of the pre-authorizations that are denied and what the reason codes would be for the denials? Will we get some kind of updates on how this is going?

Connie Leonard: Yes. What we've done in the past with our prior authorization models is as we do deal with - it's not a biannual, it's an annual update as to how the model went. Now, CMS has some experience.

We have experience with the power mobility device demonstration and those other ones we have been providing status updates on and so we do talk about how it's going and, you know, what's happening in those various states and we expect to do the same here and another thing that I know that we've been doing in the ambulance model – in the ambulance model just beginning December 1st and the MACs that had been incorporated into that model had been providing follow-up educational sessions and actually getting feedback to the suppliers as to these are the common reasons for denial so these are the

types of things that are going to need to be fixed and if we have to in this model, we'll do the same type of educational session, you know, if it's widespread.

If it's not widespread, certain facilities will conduct individualized education. That's why it's really, really around the ambulance model. It's certainly something that we want to see continue with the HBO model is individualized education to make sure that everyone understands exactly what documentation is needed, but yes, we will continue to update.

Again, it will probably be on an annual basis, but we will continue to update on just the progress of the model. Yes.

(Gina Treadwell): Thank you.

Operator: Your next question comes from (Joyce Emerick) from Western Maryland. Your line is open.

(Joyce Emerick): Hi. I was just wondering based on the slide that you had where every 30 days you had to prove an improvement in the wound will there be specifics on what you accepted improvement or is it just basically, you know, what we see?

Connie Leonard: Well the MAC is going to want documentation that there has been improvement and that would be a great question to ask the MAC when your - when they host their educational sessions as to exactly what they're going to be looking for. I believe Novitas has a local coverage determination so that they may have a little bit more detail than some of the other states and if not, but - there's always been the NCD, the National Coverage Determination, but first detailed documentation requirement is a great question to make sure you ask the MACs at their educational session so you can make sure you're providing the documentation that they are going to be looking for.

(Joyce Emerick): All right. Thank you.

Connie Leonard: Thank you.

Operator: Your next question comes from (Zubeda Brehony) from Hyperbaric. Your line is open.

(Zubeda Brehony): Hi, yes, I have a question that we give the hyperbaric treatment to the physician's office and we have lot of patient comes in to treat sensorineural hearing loss, but it is not covered - the diagnosis is not covered by Medicare, (we need something to claim to) Medicare, however, this is an approved diagnosis by the EMS and FDA so can you tell us what do we need to do in order to have this listed in the NDC?

Connie Leonard: Sure. The conditions that Medicare covered are set by the Office of Clinical Standards and Quality for the NCD and there is a process on how you can submit comments to the NCD and if you wanted to submit a comment to our mailbox, we could certainly pass it on to the appropriate physicians and commissions here at CMS so that they could take that under advisement if it's certainly not one of the conditions that are currently available under the NCD.

(Zubeda Brehony): OK. So do you have any contact info, any e-mail address or anything?

Connie Leonard: I don't right off the top with me today, but if you wanted to start something, e-mail into our mailbox, I could certainly get back to you, you know, if there is an appropriate contact here at CMS for you for this discussion.

(Zubeda Brehony): Sure.

Connie Leonard: Thank you.

(Zubeda Brehony): Well thank you.

Operator: Your next question comes from (Sue Bale) from Bronson. Your line is open.

(Sue Bale): Hi, yes. I have a question. We have a three-hospital system of which one hospital I'm in Michigan, one hospital is covered by NGS as their MAC in Michigan, is that hospital subject to this model because you say Michigan is going to be covered by W8 - J8 WPS? What do I do with this hospital that is covered by NGS?

Connie Leonard: That those - That hospital's claims will not be subject to the prior authorization model.

(Sue Bale): It will not.

Connie Leonard: It will not, no.

(Sue Bale): Can you put that in the transcript so I know that in case we get rejected.

Connie Leonard: No actually I believe we have the frequently asked question out there that kind of talk (straight) about this and so if you would …

(Sue Bale): OK.

Connie Leonard: … send an e-mail to our box, we could actually send you back that frequently asked question.

(Sue Bale): OK and I have a followup just on the - on the dates. If you have a patient that was already being treated and say they've already had 27 treatments and they're going to hit April 13th, when you ask for approval - for your prior approval, you're asking for that approval to start on April 13th, how many - are you just asking for a date to go through you're only going to get the 40 treatments or total 40 treatments or are you going to get 40 treatments from April 13th authorized?

Connie Leonard: Well you - it's going to be the number of treatments that you need from April 13th until the end. So with that particular beneficiary if you felt they only needed, you know, 10 or 15 more treatments, you would only request the 10 or 14.

The MAC will look at each, you know, when they're making that review process, they will try to make the determination of how many treatments will be necessary so if someone has already been getting 27 days of treatment, it may not be appropriate for them to get 40 whereas 10 or 15 or whatever number, you know, more so especially in the beginning when you do have beneficiaries who have been getting treatment for quite some time, you know, that number may (vary up) to 40.

(Sue Bale): So in other words, again, you're just saying how many treatments you feel from April 13th on you're going to need for that patient.

Connie Leonard: Correct.

(Sue Bale): OK and the last question, do you have a date of which you told the MACs they have to start this education?

Connie Leonard: We do not have a date, but I know that we are in contact with the MACs on a regular basis and they've all said that they planned to have them this month. I do not know right now what the dates are. I don't have them with me, but I do know that they are scheduling them for this month.

(Sue Bale): OK because I just looked they are in WPS J8 site and there is nothing.

Connie Leonard: OK. We will check with them this week to see when they plan to update the Web site, but I do know they're planning educational sessions.

(Sue Bale): OK. Thank you.

Operator: Your next question comes from (Sean Frogman) from East Orange General. Your line is open.

(Sean Frogman): Good afternoon. I have a question. The PDF that's up on the Web site is dated December 10th and the information on their conflicts with what you've set up to date so that's going to be revised and changed at the end of the phone call.

Connie Leonard: That's the site presentation right?

(Sean Frogman): Yes, the December 10, 2014 HBO prior auth. ODF.

Connie Leonard: Yes, we will be updating it with today's slides, which do say February 3, 2015 and they do have the updated changes in it and that should be up this afternoon.

(Sean Frogman): OK because I refresh my page several times thinking maybe I just wasn't seeing it and …

Connie Leonard: Right.

(Sean Frogman): … I was trying to follow your discussion and it seemed discongruous.

Connie Leonard: Yes, it does a little bit, yes. So we will make sure that they will be up this afternoon and if after you get the slides if there are further questions, please e-mail us for it.

(Sean Frogman): And as such if I could just bear with me …

Connie Leonard: Yes.

(Sean Frogman): … the start date for the MACs is March 1st to accept paperwork …

Connie Leonard: Correct.

(Sean Frogman): … only with reference to patients who are in or pending treatment for April 13th no longer March 15th.

Connie Leonard: Correct.

(Sean Frogman): OK so that's - that's the huge difference that you pointed out and again that wasn't on the slides and you said it bumped up to 40. OK. Thank you very much.

Connie Leonard: And on the new slide deck, it's going to be slide 7.

Operator: Your next question comes from (Becky Wovington) from McLaren. Your line is open.

(Becky Wovington): Hi. I think you've answered my question since I posted to have one and that is just how are we going to know when the MAC education is going to take place, but it sounds like we have to just keep checking their Web site.

Connie Leonard: Keep checking their Web sites and I do not know if that MACs have LISTSERVs available for HBO, but we'll certainly find that out this week and if they do, we'll post the links to our Web site, which will make it a little bit easier.

(Becky Wovington): OK.

Operator: Your next question comes from Tom Norton from Neurologics. Your line is open.

Tom Norton: Yes, I know that Critical Access Hospitals are not going to be subject to this program, but I'm wondering how will you identify them, will it be by their billing code or will it just be by CPT code that's used?

Hello.

Connie Leonard: We were thinking that the type of bill was different for a Critical Access Hospital. Is that not the case?

Tom Norton: No, it is.

Connie Leonard: OK.

Tom Norton: It is different. It's an 85 code so …

Connie Leonard: OK.

Tom Norton: … is that how you will?

Connie Leonard: That is, yes.

Tom Norton: OK.

Connie Leonard: You get me there for a second.

Operator: Your next question comes from (Ferris Gulley) from William Beaumont Hospital. Your line is open.

(Ferris Gulley): Yes, I'm confused as to the retroactive approval process. For example if I have a patient come again with diabetic foot ulcer, he needs treatment soon. I don't want to wait two weeks. We can't wait two weeks for the sake of the patient. How many treatments am I allowed to order? Is it 20? Is it 40?

And that also goes for radiation. Let's say patient comes with radiation cystitis, how many treatments am I allowed? Twenty? Forty?

Connie Leonard: You will have to actually request just 40 treatments. It doesn't matter what the condition is. You can request up to 40 treatments.

So if it's a diabetic foot ulcer, you request 40 treatments and if - and in the beginning as soon as you know that you're in the HBO therapy, you know, maybe you get to Day 25, you know, I don't know when you might make that decision you're going to go ahead and submit that request. Even if it's Day 30 and you said oh I got to go and do this HBO, you're going to be getting the treatment right away.

You're going to submit your request for that date, Day 1 of your HBO therapy and you're going to request the number of treatments that you think is appropriate be it 20 or 30 or 40 whatever that number is. It cannot be above 40 though and then you're going to submit your request. You will want to wait until you receive a decision before you submit all of your claims.

Now if you were providing a treatment, you have your affirmed request and, you know, there's - there's progress being made with the therapy, but you know they're going to need more than 40 so on Day 30 or so, you say there's - I can have evidence of progress, evidence that, you know, the wound is beginning to heal or to make progress then you'll go ahead and submit that second request, you know, be it for 20 more sessions or however many sessions you think is necessary.

So the way the retroactive is, is we want you to begin the therapy and submit the request. We don't want you to wait to get the affirmation before you begin a therapy. We want you to begin the therapy and then submit all the verification and then submit the claims once you get that affirmed with that.

(Ferris Gulley): OK so basically what you're saying is if I get a patient I believe I have to treat him right away I can start to treat him, submit the information, let's say the case of a diabetic foot ulcer, request 40 treatments and then when we, you know, the normal process is after one month of therapy, we reevaluate so one month of therapy would let's say be 20 treatments, we reevaluate, we see

measurable signs of progress then we resubmit that to you and then we continue on until 40 treatments are completed and if it required beyond 40, we again do the same process where we have to get further approval. Correct?

Connie Leonard: Correct, but the only point I just want to make sure everyone understands is when you reevaluate at 30 days just like you said and that's 20 treatments as long as you're affirmed with 40 sessions, you don't have to come back into us and so you decide if you need more than 40.

(Ferris Gulley): Oh OK so basically what you're saying is I have a diabetic foot patient, I could treat immediately …

Connie Leonard: Yes.

(Ferris Gulley): … submit the data, correct?

Connie Leonard: Yes.

(Ferris Gulley): And then get retroactive approval, continue treatment until let's say 40 as long as he is improving and I don't have to resubmit a claim at after one month.

Connie Leonard: Correct. You do not have to resubmit unless for some reason the number of treatments that you'd requested in the beginning or that was affirmed in the beginning was less than 40, but we'll just assume that it was 40, you don't have to come back in again until you think they're going to need more than 40.

(Ferris Gulley): OK now, you know, just this, sorry, just bear with me because this is a very critical point, what if I request 40 and then I've only given 20?

Connie Leonard: If that was the case then you're absolutely correct. When you did your 30-day assessment, you have to come back in again.

(Ferris Gulley): But that's a major problem because then there's a significant delay in the care of the patient because if I have to wait to, you know, 10 business days, I have a patient who is doing quite well, he's demonstrating, you know, excellent progress, I need therapy so I'm given 20 treatments and then I have to wait a full two weeks where the patient could have given 10 treatments and we're not giving him anything.

Connie Leonard: No, we won't - we will not want that to occur though. We will want therapy to continue and I believe that in those cases unless, you know, the indicators are not that should be more than 30 or 40 approvals, which I don't think is the case for the diabetic wound that the approval most likely is going to be the 40 cases, the 40 treatments, I'm sorry and you'll be able to go through 40 treatments and then come back in just to show us you need it after 40.

Most of the indicators that I have looked at from some of the literature had been in the - in the 40 range so there are some that's a little bit lower between. You probably know that much better than they know.

(Ferris Gulley): Yes so what you're - what you're telling me basically is that we're going to get approval for 40 initially.

Connie Leonard: If your documentation is there, I believe …

(Ferris Gulley): Yes.

Connie Leonard: … yes that's what's going to happen, yes.

(Ferris Gulley): Yes so because we're very strict with documentation, the documentation definitely will be there, but we request 40 and that way there's going to be, you know, no, you know, the patient is going to have, you know, continuity of care.

Connie Leonard: Correct absolutely. Continuity of care is very important.

(Ferris Gulley): All right and then with respect to the retroactive approval process when you say go, you know, go ahead and dive the patient before we get approval …

Connie Leonard: Yes.

(Ferris Gulley): … OK. Now, you know, one concern I have and that is consistency with the reviewers. Now, you know, sometimes you can have a, you know, I'm worried that I can have a reviewer who can look and tell me for example well, you know, the patient - we don't see the patient has chronic, you know,

osteomyelitis of the foot because the patient doesn't have a biopsy of the foot. Next, reviewer two would say well an x-ray is enough.

I'm concerned that if we do this you get one reviewer who will accept the patient and say "OK you can dive and get claims" and the - I may get another reviewer the next month with a different patient who will require a different set of criteria and I've heard of this happening, you know, 10 years ago. I've been doing this for quite some time and then if we start diving the patient, then we're going to have to make up, you know, the difference. The patient might have to pay the bill or the hospital.

How are we going to be assured that if we are going to start therapy without pre-approval that there's going to be a fallback let's say it is rejected as a physician I could speak to another physician like I can with other insurance companies that require preauthorization and once this physician to physician it takes it to a different level where we have that – where we have that? Yes.

Connie Leonard: I'm sorry. I didn't mean to cut you off, but …

(Ferris Gulley): Yes, my question - my question Connie is, I'm sorry for my questions guys, you know, you understand what can happen. We can treat a patient immediately. We can get rejected where we think we should be approved.

Connie Leonard: Yes.

(Ferris Gulley): The patient is going to be unhappy because they're going to get a bill. The hospital is going to, you know, have to pay for this and is there a recourse where the physician I could say "hey let me speak to another physician and explain my point like it could let's say for Blue Care Network and other insurances."

Connie Leonard: There is. Each of the contractors, it has a contract and medical director that is available to speak to physicians that I do know that in the (ambulance) model and the PMD model they still have had discussions with physicians about the particular claims and that somebody would have to hear and we're just as concerned as you were about the consistency. It's another one of the reasons

why we kind of would have the six week kind of ramp up time we want to take.

This is not the claim type that's reviewed by these MACs on a large scale basis so we do want to make sure that everyone understand the documentation requirements that's why we're - we're working together with some associations to make sure everyone has the same understanding starting from the same, you know, level of playing fields so to speak.

CMS is looking into if we have to put on a training for these MACs to get all in efforts to make sure that just as you said that you don't have one approval, you know, by one reviewer and then the same kind of documentation be denied by another reviewer. That is definitely something that CMS is very concerned about and we're trying to do what we can to mitigate that and make sure that that doesn't happen.

(Ferris Gulley): So we will be given a telephone number so if something does occur I can talk to a medical director very quickly because like I said I'm for preauthorization I understand the reasons to that, but it has to be done properly and with other insurances that have preauthorization I can talk to a physician within 24 hours.

Connie Leonard: I can't say that you will have a phone number where you'll be able to call the physician, but I you'll likely get a callback within 24 hours.

(Ferris Gulley): By a physician?

Connie Leonard: Oh by the medical director, yes.

(Ferris Gulley): OK and I'm sorry, one more question as a plastic and reconstructive …

Connie Leonard: OK.

(Ferris Gulley): … as a plastic and reconstructive surgeon, when you're talking about flaps right as being a non-emergent therapy, I could tell you for a fact that a failing skin graft or a failing flap is an emergent therapy and should really be excluded from this model. I have my fellow plastic surgeons calling me they have - they've done a head and neck reconstruction where they reconstructed

a nose, call me on my cell phone telling me the flap is failing, we have to get this patient in right away.

Skin grafts are the same thing. I mean there is - it doesn't make absolutely any sense to include them as non-emergent. Failing skin grafts and flaps are emergencies.

Connie Leonard: Thank you. You're not the first to have told us that I'm sure as you know. We will continue to discuss that internally and if that's something that we do decide we want to change, we'll certainly update you guys on our next call.

We'll take that as new advisement. Again, we'll talk with some of the physician groups here and let the MACs see what their thoughts are about skin grafts and flaps. Thank you.

(Ferris Gulley): OK. Thank you so much.

Connie Leonard: Thank you.

Operator: Your next question comes from (Iris Daniel) from Hyperbaric Medical. Your line is open.

(Iris Daniel): Yes, I just wanted to clarify one thing. Our hyperbaric facilities, doctor's medical office until now we were just filling 99183 so starting January, we had to bill 99183 along with G0277 code. Is that correct?

Connie Leonard: The G - The G0277 code is the facility code so if you're performing this in the physician's office, you should continue to bill the appropriate code for providing the treatment at the - at the physician's office.

(Iris Daniel): What I read in the …

Connie Leonard: If you …

(Iris Daniel): What I read in the CMS guidelines is they eliminated the C1300 code and they added the G0277 code to be added for all places of services just not the hospital and everyone has to give the time whatever 30 minutes' time and we have to along with the 99183 from this code as well.

Connie Leonard: If you would - If you are looking just for this clarification exactly how you should be billing if you wanted to send the question in to our mailbox, we could certainly make sure we get it to the right people and get the right answer for you.

Again, the rule - the rule has been changed, but I do know the code changed as of January 1st so we certainly would be happy to track down the right answer for you and that's the HBOPA@cms.hhs.gov e-mail address. We'd be happy to make sure we get the right answer for you.

(Iris Daniel): E-mail.

Connie Leonard: And I think we have time for one more question.

Operator: OK. Your next question comes from (Jewel Crider) from WCM. Your line is open.

(Jewel Crider): Hi Connie, it's (Jewel). Thank you so much for all the work that you did on this call and we appreciate the changes that were made.

I've got a couple of quick questions on those changes. First, with respect to the extension of the go live date until April 13th …

Connie Leonard: Yes.

(Jewel Crider): … I understand you're looking for some volunteers to start submitting claims in early March, are you looking for folks to work with the MAC, submit claims only for those patients that would require service and will be continuing or starting service after April 13th or are you looking to trial the paperwork for patients that are currently receiving service, but may not be continuing on after the 13th of April?

Connie Leonard: Actually both (Jewel), we really love to if we could get at least one volunteer in each of the jurisdictions that would almost be willing to kind of do that trial. I think it's beneficial both for the MAC and for the facility.

(Jewel Crider): Great.

Connie Leonard: Again, there's - there's no repercussion there. It's just to make sure the facility is submitting the proper documentation to really help CMS from a consistency perspective so we're looking for facilities that would be willing to kind of do that trial with kind of current claims probably now, but they also, you know, as we near our early April probably and start getting in those that are going to be still getting treatment, we obviously want to get those in too.

(Jewel Crider): Great. And then I had a second follow-up question on the retroactive authorization. The example you gave was for the diabetic foot wound, am I to understand though that it could be applied to any of the diagnoses, any of the six diagnoses?

Connie Leonard: Yes, it does. It could be applied to any of them. I just gave the example with you in the diabetic wounds because that's the most prevalent comment we get about you needed to start therapy immediately and such, but it is for all six conditions.

(Jewel Crider): Great and then along that line, I know that the provider can ask for an expedited response …

Connie Leonard: Yes.

(Jewel Crider): … given that they can get retroactive prior authorization, is there a need to go expedited or is there a benefit of doing expedited over just waiting for the right …

Connie Leonard: You're right (Jewel). We do believe with this retroactive process that there's probably going to be very few need for an expedited. We left the expedited there.

We did talk internally about if we would just put it to retroactive. We left it there, but we don't believe it's probably going to be used very much with the retroactive and I will tell everyone and I know we are at our time that in the ambulance model and in the PMD model where the MACs do have 10 days, most decisions are actually made in three or four days so there is a pretty fast turnaround time. Even though the MACs have 10 days and then 20 days of

reconsideration, it is not taking really that long. I don't expect to see in this model either.

(Jewel Crider): Great and I want to squeeze in one last question for after someone completes their 40 dives and needs to submit for additional, reference 40 and a response that you didn't or excuse me, you referenced that there would be 20 for reauthorizations, but that wasn't formally in your - in your formal comments, was I correct in understanding that the reauth would be up to 20?

Connie Leonard: Oh no, it would be up to 40. I just probably was just using an example if they needed 20 more.

(Jewel Crider): Oh.

Connie Leonard: So it could be up to 40.

(Jewel Crider): The first auth. can be up to 40. The second reauth would also be up to 40?

Connie Leonard: Correct, we don't have a - we have not placed a limit on the second one.

(Jewel Crider): OK great. Thank you for that clarification and again thank you so much for all you've done and listening to everybody to make these changes.

Connie Leonard: You know I appreciate everyone's feedback. It's been very helpful. Thank you.

And with that, I think we've reached the end of our hour. I greatly appreciate everyone taking the time today to give us great feedback. It's very much appreciated and it's really helped CMS greatly.

Again, if you have follow up questions, the e-mail box is HBOPA@cms.hhs.gov and we'll be happy to answer your questions. Keep looking out on our Web site and the MAC's Web site for the educational opportunities.

Thank you all. Have a great afternoon.

Operator: This concludes today's conference call. You may now disconnect.

END