

CENTER FOR MEDICARE & MEDICAID SERVICES

Center for Medicare and Medicaid Innovation
Special Open Door Forum:
Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy
Tuesday, November 4, 2014
1:00-2:00 pm Eastern Time
Moderator: Jill Darling

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

All lines have been placed on mute to prevent any background noise. After the speakers' remarks there will be a question and answers 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, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you and hello everyone. Good morning and good afternoon. My name is Jill Darling in the CMS Office of Communications and again, welcome to today's Special Open Door Forum on Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy. So let's get started and I'll hand the call off to Connie Leonard, Provider Compliance Group Deputy Director.

Connie Leonard: Thank you, Jill and thank you everyone for joining us this afternoon. This is our very first call, specifically for the Prior Authorization of Non-Emergent Hyperbaric Oxygen Therapy. So today, we are going to do a short

presentation going through some of the specifics and then we will turn over to a question and comment period.

We may not have all the answers that everyone may be looking for today but we're very interested in getting your feedback and your questions and your comments as we work to implement a successful program and with that, I'll turn it over to Angela and Jennifer for the presentation.

Jennifer McMullen: Hello, this is Jennifer. The purpose of this model is to establish a three-year prior authorization process for Non-Emergent Hyperbaric Oxygen Therapy and to ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments 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 review before a service is rendered to a beneficiary and before a claim is submitted for payment. Prior authorization helps ensure the applicable coverage, payment and coding rules are met before services are rendered.

Some insurance companies 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 a 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 clinical conditions listed in the NCD, six 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; Actinomycosis only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical

treatment; Diabetic wounds of the lower extremities in patients who meet the following three criteria – the patient has type 1 or type 2 diabetes and who has a lower extremity wound that is due to diabetes, the patient has a wound classified as Wagner grade 3 or higher, and patient has failed an adequate course of wound therapy as defined in the NCD.

The model will begin in early 2015 and continue for three years. It will take place in Illinois, Michigan and New Jersey.

The following HBO HCPCS code is subject to prior authorization, C1300-hyperbaric oxygen under pressure, full body chamber, per 30 minute intervals. Prior authorization is only needed for the facility payment part of the HBO therapy service. However, if a facility does not have prior authorization or has a non-affirmed prior authorization, the associated physician claims with the following codes will be subject to medical review -- 99183 physician attendance and supervision of hyperbaric oxygen per session.

Medicare coverage policies are unchanged. Documentation requirements are also not changed and time frames for HBO therapy are not changed. The model does not create any new documentation requirements. It simply requires the information be submitted earlier in the claims process. Current requirements can be found on the Medicare A/B MAC Websites.

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 the HBO therapy. Continued treatment with HBO therapy is not covered if measurable signs of healing have not been demonstrated within any 30 day period of treatment.

Also unchanged is that the A/B MAC will conduct these reviews, all advanced beneficiary notice policies are followed and claim appeal rights.

What has changed? The facility will know before the service is rendered whether Medicare will pay for the service. Upon request, the beneficiary will be notified before the service is rendered whether Medicare will pay for the service. CMS will reduce reliance on the pay achieve method of post pay review appeals to reduce improper payment.

The prior authorization request as of October 31, 2014 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 facility's name, NPI and address, the requestor's name and telephone number, the procedure codes, submission date, the start of 12 month period, and the number of treatments requested.

You must indicate if the request is an initial or a 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. I would now like to turn the presentation over to Angela Gaston to continue.

Angela Gaston: Thank you Jennifer. Number of treatment courses: A provisional affirmative prior authorization decision may affirm up to 36 courses of treatment in a 12-month period. If additional sessions are needed in excess of the 36 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, or submitted through the esMD system.

Review timeframe: For the initial request the MAC makes every effort to review requests and postmark decision letters within 10 business days. Resubmitted requests are requests submitted 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 timeframe could jeopardize the life or health of the beneficiary. However, under this model this should be rare since this is for non-emergent services. 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 or provide the service and submit the claim. That claim will be denied but all appeal rights are available. For non-affirmed prior authorization requests, unlimited resubmissions are allowed. These requests are not appealable, however for denied claims all normal appeal rights apply.

Unique tracking number: The MAC will list the prior authorization unique tracking number on the decision letter. This tracking number must be submitted on the claim. 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.

What happens if you don't use the prior authorization process? If a facility has not requested prior authorization, the claims will be stopped for prepayment review. The MAC sends additional request letter and waits 45 days for a response. The MAC reviews 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 slide summarizes the different scenarios that can occur. Scenario 1, the prior authorization request is submitted, the MAC decision is affirmed. The facility can then render the service, submit the claim, the MAC will then pay the claim as long as all other requirements are met.

Scenario two, prior authorization request is submitted; the MAC decision is not affirmed. The facility can then either a. submit the claim, the MAC will then deny the claim or b. fix and resubmit the prior authorization request.

Scenario three, prior authorization request is not submitted therefore there is no MAC decision. The facility can then choose to render the service and submit the claim. The MAC will stop that claim for prepayment review. 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 beneficiary impact, the service benefit is not changing. The beneficiary, 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 Websites. Illinois, you are in jurisdiction J6 NGS, Michigan is in jurisdiction J8 WPS and New Jersey is in jurisdiction JL-Novitas.

You can also find additional information on the CMS HBO prior authorization model Website at <http://go.cms.gov/PAHBO>. There you can find the fact sheet, frequently asked questions, background information, and information on open door forums including the slides for today's presentation.

In summary, the model – the HBO prior authorization model begins in early 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.

You can also e-mail questions to the prior authorization team at HBOPA@cms.hhs.gov and I will now pass it back over to Connie for questions.

Connie Leonard: Thank you, Angela and before we turn it over for question and comment period, just a few highlights from the presentation. Again, the model will occur in Illinois, Michigan and New Jersey some time in early calendar year 2015. As we get closer to the implementation date there will be an announcement of the start date and there will be educational sessions that will be offered by the three MACs in each jurisdiction.

We will also have more open door forums as we keep getting comments and feedbacks from the industry. No coverage requirements are changing. The NCD and the applicable LCDs will apply; we're not modifying any of the coverage requirements. When Medicare prior authorization just means that we are reviewing all of the medical documentation before the service is provided.

You will submit the same thing that you might submit today for a prepayment or post payment review. All of the required documentation must be submitted for the prior authorization to be affirmed and as Angela and Jennifer stated, unlimited resubmission of documentation can be submitted so therefore if you forget to send something or do not have enough documentation the first time, you can resubmit with your additional documentation and hope that as we move forward, documentation will improve.

And lastly, before we turn it over to the Q&A, please be respectful of everyone on the call and have one question per caller. Should you have additional questions, please get back in the queue or if you cannot you don't get an opportunity to ask a question today, please send your questions to the mailbox, that was HBOPA@cms.hhs.gov and with that we can open the line for the question.

Operator: As a reminder, please press star and the number one on your telephone keypad if you would like to ask a question. If you would like to withdraw your question, press the pound key and again, please limit your questions to one

question and one followup to allow participant time for questions and you may press star one again to rejoin the queue if you have further questions.

Your first question comes from the line of (Susan Meltzer) at MCHD, your line is now open.

(Susan Meltzer): Hi, thanks for taking my question. I just wanted to verify that it is only the hospitals that are serviced by NGS in Illinois that will be part of this prior authorization project that it will not include the hospitals that are serviced by WPS through the national contract?

Connie Leonard: That's a very good question, (Susan). I'm going to take that back and I'm going to get some follow-up for you. I would say that if someone in the state of Illinois is serviced by another MAC outside of NGS, for example if their serviced by another, they would not be included in the model but since WPS is included in the model I want to take that back and give you a firm answer, if you would send that question to the mailbox we'll get the answer right back out to you.

(Susan Meltzer): Great. Thanks so much.

Connie Leonard: Thanks, (Susan).

Operator: And your next question comes from the line of (Adam Schaffer) at Oakwood Healthcare, your line is now open.

(Adam Schaffer): Yes, hi. I just had a quick question regarding if needed for the extension beyond 36 treatments, how early in advance would you need that submission so that no delays in the patient's care occurs.

Connie Leonard: I would suggest submitting that request at least 20 days in advanced, typically only 10 is necessary for the approval but I think that just buys a little bit of time in the event you have to resubmit and submit additional documentation so my suggestion would be two weeks or 20 days in advance.

(Adam Schaffer): Thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Tammy Nees) at Manor Health, your line is now open.

(Tammy Nees): Thank you. Yes, I wanted to ask what is the Web site again, I didn't quite catch that I apologize for the go CMS for this presentation today.

Angela Gaston: Sure, it's <http://go.cms.gov/PAHBO>.

(Tammy Nees): Great, thank you.

Operator: And your next question comes from the line of (Alex Welkofsky) at Detroit Hyperbaric, your line is now open.

(Alex Welkofsky): Hi, how long does it generally take authorization?

Connie Leonard: Could you repeat the question?

(Alex Welkofsky): How long does it generally take for authorization?

Connie Leonard: Yes, the MAC will have 10 days to approve the prior authorization.

(Alex Welkofsky): Whether it is emergency or non-emergency?

Connie Leonard: No, if it requires an expedited approval then it will be two days and we are going to work with the MAC to develop scenarios where we believe an expedited review maybe necessary, and we are very interested in hearing feedback from providers and we would suggest that if you have scenarios where you believe an expedited review might be necessary to please send them through the mailbox.

(Alex Welkofsky): OK. Thank you.

Operator: And your next question comes from the line (Sue Viel) out of Bronson Hospital, your line is now open.

(Sue Viel): Yes, I have another question similar to the first question. We have – we are an integrated system and one of our hospitals is serviced by NGS out of

Michigan and one is WPS and we have hyperbaric at both those so will be NGS facility that they are serviced by NGS will they be subject to this?

Connie Leonard: That's a great question and we're going to get more feedback up on our Web site about these hospitals that might be serviced by another MAC especially when the MAC may very well be participating in another jurisdiction so we'll get some clarifying information up on our Web site.

(Sue Viel): OK, thank you very much.

Connie Leonard: Thank you.

Operator: Your next question comes from the line of (James Home) out of VI Meza Medical; your line is now open.

(James Home): Hi, (Jim Home) the president of Undersea and Hyperbaric Medical Society and I applaud CMS' activities. The only concern I have and I'll probably subject it via e-mail is that the compromise flap and graft indication is one that generally was designed to be treated on an urgent basis.

Although folks have used it later to treat patients and that window would be somewhat long so I think the last question you answered that the expedited review may – this indication that you did include would be one that we really would want to get on top of and treat early.

So if you have any feedback of how best to express that, that was the one that jumped out that probably really couldn't wait or shouldn't wait for the patient's best interest.

Connie Leonard: Thank you, Jim. I appreciate that comment and I would do just as you suggest please send that into the mailbox, that scenario. If anyone, you know, attending this call you know has concerns with any of the six conditions that we've lifted that you feel that in those cases they might be emergent, the intent here is to prior authorize non-emergent services so if you have scenarios with any of these conditions, please send them to the mailbox so we can take this under further review.

(James Home): Thank you very much.

Connie Leonard: Thank you.

Operator: And your next question comes from (Alex Welkofsky) from Detroit Hyperbaric, your line is open.

(Alex Welkofsky): Hi, again. The prior authorization will be required for both hospital owned and free standing facilities?

Connie Leonard: If you are billing under the outpatient payment system then it is required. It is not required for services performed by the physician in another location outside of OPSS but if you're billing under the OPSS then it is required to be prior authorized.

(Alex Welkofsky): So, if we just billing physician services, which is 99183 prior authorization, is not required?

Connie Leonard: That's is correct but if you're billing 99183 and there is not an equivalent facility code then that physician's claim will be subject to review potentially.

(Alex Welkofsky): And the only one that really requires prior authorization is C1300, right?

Connie Leonard: That is correct.

(Alex Welkofsky): OK, so as long as that documentation is fine we don't need to submit for prior authorization if we are free standing facility?

Connie Leonard: If you are a free standing facility that only bills the 99183 then you would not be required to submit for prior authorization. If you bill the C1300 then you would. If you have further questions I would appreciate you getting back in the queue just so we could allow potential other callers to continue to ask questions or send through the mailbox, we can have a dialogue.

(Alex Welkofsky): Thank you so much.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Tiffany McFadden) at CHC Wound health healing center, your line is now open.

(Tiffany McFadden): Hi, will there be a pre-form that we can fill out?

Connie Leonard: We will work with the MAC to develop a cover sheet or a documentation list, its similar to what we've created for the other prior authorization demonstration models that we have. So we know, it will not be a required form but I do know that in the other two model demonstration the suppliers appreciate and MAC appreciated as well. So there will be something very similar that you will be able to submit with the request.

(Tiffany McFadden): Great, thank you.

Operator: And your next question comes from the line of (Vanessa Truvella) at Alexi and Brothers, your line is now open.

(Vanessa Truvella): Yes, hi. Good afternoon. You said when we get affirmative prior authorization the next number is 36. Does that apply to all diagnoses?

Connie Leonard: That is a very good question and I want to get confirmation on that. We will make sure to update our Frequently Asked Questions on our Web site with that detail just so we can – I want to be sure I'm answering it correctly.

(Vanessa Truvella): OK, thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Sue Bill) at Bronson Hospital. Your line is open.

(Sue Viel): Yes, so I just want to find out exactly the documentation that you're expecting to see for that prior authorization such as you're expecting to see start of the wound care and (definite). Do you want pictures, do you want measurements of the wounds to justify that they are not healing? What is it that you expect to see for that prior authorization?

Connie Leonard: I would suggest to you look at the LCDs for your particular jurisdiction or the articles or summary statements that are out there from the MAC as well as when the MAC have their educational session. Really ask for the type of information that they are looking for when they review these cases, you know, cases that they review today, so they're not going to be changing their review guidelines. They're not going to be changing their LCD or any articles out there.

I really suggest, you know, asking these question of the MAC and looking for what they asked but if you're in any states or just with us, LCD typically they do have documentation requirement in the LCD and as well as some of the articles might actually have this details too.

(Sue Viel): OK, thank you.

Operator: And your next question comes from the line of (Helen Gelley) at UHMS. Your line is now open.

(Helen Gelley): Hello. I would like to ask the question about the timing of the diabetic foot wound preauthorization because the – one of the criteria is a 30-day evaluation and then no progress after 30 days and yet you suggested that we list the preauthorization after only 10 hyperbaric treatments, so that the 20 days that would be required for the secondary authorization will be available before the end of the 36 treatments that were authorized the first time.

So if you could go through that time frame where we're going to be submitting documentation that is inadequate by virtue of the fact that it won't satisfy the 30-day improvement criteria.

Connie Leonard: Thank you for that and we certainly have heard from some concerned individuals about the diabetic foot wounds especially. And I very much appreciate it if you could send that comment into the mailbox with that particular scenario because we are considering what options we might have as far as – we don't want to impact the beneficiary's access to the therapy, especially if they can save the limb.

And so I really would appreciate if you could actually write this up into our mailbox, paint it with this scenario and the different time frame. Like for example Medicare, the NCD requires that the 30 days of standard treatment. And so if you are to submit your initial request on day 15, does that allow enough time or day 25 as we did an expedited review to turn that around, to be able to (one), start the HBO as soon as you possibly can, you know, following the NCD.

And then it would be very good if you could follow up – if you're talking about follow-up course of treatment where you're getting, you're resubmitting and trying to get, you know, a second treatment authorized. You know if we're talking in terms of, you know, the 36 treatments and what is the period time that's going to allow you, then I think we can – we can work to try to tailor for the prior authorization program a little bit more to make sure we're meeting everybody's requirement. So I really appreciate if you could write that up, just so we can have a fuller understanding.

(Helen Gelley): I would like to do so but as a corollary will there be – is 36 treatments the maximum number or is it the first go-round that is authorized as 36 treatments and then the second prior authorization would allow for how many additional treatments?

Connie Leonard: The current guidelines for 36 treatments in a 12-month period of time, so I would – again if there are concerns from providers regarding that number we certainly appreciate it in our – in our mailbox, so that we can take that under advisement.

(Helen Gelley): Right, thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from (Tammy Niez) at the Banner Health. Your line is open.

(Tammy Nees): Hello again. I have the question, I see that it's – you're stating that the prior auth is going to impact Illinois, Michigan, and New Jersey and this will be for three years. My question is after that three years or even prior to the three

years will other states be implemented, is that – has that been discussed or if it will just go nationwide after three years?

Connie Leonard: It has not been discussed as of yet as to if we will expand to other states or extend beyond the three-year period of time. For CMS to go nationwide, we would actually need statutory changes. We do not currently have the ability to do this nationwide. You know, we are testing this and testing how prior authorization works with hyperbaric and hyperbaric oxygen treatment.

We believe we will get very good results and evaluation criteria as we work to determine if this is something that we like to request to be able to do nationwide. But as of now, it will stay a demonstration or a model. It is possible at some point we could expand to other states but it has not been discussed yet and there are no current plans to do it.

(Tammy Nees): Excellent, thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from (Cathy Boyle) at Restorix Health. Your line is open.

(Cathy Boyle): Yes, hi good afternoon. I would like to know, having responded to previous audits on this very service, the documentation can be voluminous, is there a limit on the number of pages that can be sent for prior authorization or is that not going to be a problem, especially if you require all of the previous wound care visits that a patient has had prior to their starting for say a diabetic foot ulcer. It's usually fairly extensive.

Connie Leonard: No, there is no limit on the amount of documentation that you can submit. You should submit everything that you feel is necessary to support the payment of the claim or the affirmation of the prior authorization. There is no limit.

(Cathy Boyle): Thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Adam Shaffer) at Oakwood Healthcare. Your line is now open.

(Adam Schaffer): Yes my question is regarding the referring to the NCD in Michigan. In 2000 or in the end of 2013, WPS retired the LCD for hyperbaric and had us start utilizing the NCD which is very vague. Can we refer back to that retired LCD for WPS for more specific requirements for guidelines and documentation?

Connie Leonard: That's a great question and I would suggest asking that at WPS at the educational session but we will also ask that of WPS to see if those expired documentation requirements are a good place for providers to begin as they try to make sure they've submitted everything.

(Adam Schaffer): Thanks.

Connie Leonard: Thank you.

Operator: And your next question comes from (John Peters) at UHMS. Your line is open.

(John Peters): Yes, thank you. My name is (John Peters). I'm the executive director of the UHMS and I am – I want to comment on the new 2015 OPFS final rule and the change in the HBO HCPCS code. You continue to reference C1300. The new code is now G0277. Is this going to be referenced in proper education, going to be disseminated to the marketplace before this happens?

Connie Leonard: Yes, thank you. We also were recently made aware of that change and we are still investigating the impact on the demonstration. So, I appreciate you bringing that up and we will make the necessary changes and make sure that this was part of our education as to change of – to the G code. Thank you.

(John Peters): Thank you.

Operator: And your next question comes from the line of (Vanessa Truvella) at Alexian Brothers. Your line is open.

(Vanessa Truvella): Yes, hi good afternoon again. Just question with reference to, our MAC is actually WPS but our FI is NGS, so if – if I heard you correctly, this only

applies to NGS. So if the – our physicians do not need to do any prior authorization, with WPS being our MAC, we – it doesn't really apply, we don't really need to do prior auth. How will that affect our physicians?

Connie Leonard: So, that is one of the questions that we want to provide an update for on our Web site as to what's going to be impacted with WPS let's say you have some nationwide providers. So, look out on our Web site in the near future for just some updated information about providers or facilities that have an FI who is not, you know, one of the three participating in the model or is WPS on a nationwide basis.

(Vanessa Truvella): OK, thanks.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (John Peters) at UHMS. Your line is open.

(John Peters): Thank you. This is a followup to the previous question with you HCPCS Code G0277. Now that the code is open for physicians as well as physician office billing for technical services as well as hospital-based, are physicians who are now billing the new G0277 as a technical, will they be required to also submit preauthorization. This is just a clarification of something that was stated earlier.

Connie Leonard: Sure, thank you because that certainly the way I had read the new rule too was that the HCPC is now open for physicians but our current model is set up to only prior authorize the facility. So if a physician is billing the G0277 for treatment that occurred, you know, outside the facility, they currently would not be required to participate in the prior auth demonstration.

If there are going to be any changes or modification to that because of this code change, we will certainly keep the public updated through open door forums and to our Website but as of today it's still just a facility.

(John Peters): Thank you.

Connie Leonard: Thank you.

Operator: And there are no further questions. One just came up, (James Holmes) from (inaudible) Medical. Your line is open.

(James Holmes): Thank you. Just one other question, if a patient – this doesn't – my understanding this doesn't apply to any patients that are inpatient they're being treated for these indications. And two is, if someone transitions from an inpatient setting where they needed indication and is treated as an outpatient and maybe some of the other indications, is that – and they need to be continued on treatment and not disrupt their treatment, is there a way to retrospectively or apply while you're ongoing providing treatment, so you don't disrupt the inpatient, outpatient flow?

Connie Leonard: You are correct that the inpatient treatment is – does not – it's not prior authorized. That's included in the – in your inpatient payment and we certainly follow that there will not be – we would not want to disrupt a particular patient's line of treatment.

We will – we will take that back and think about ways that we might be able to facilitate those types that might be an example of an expedited review and then also just to remind everyone that if there's a particular situation that they're just in a – in the physician's judgment there is no time for the review, this is – the prior authorization, use of the prior authorization as voluntary but that claim will get stuck for prepayment review.

So, there is always the aspect, you know that you could continue with treatment and then submit it for prepayment review but we'll take that particular scenario back to that inpatient and switching over to the outpatient and how we can best work with that. Thank you.

(James Holmes): Great – just a – will a physician review, the expedite reviews or is it not necessarily a physician or how does that work?

Connie Leonard: It's not necessarily a physician; however, the MAC used a clinician to conduct a review but they all have physicians at their disposal.

(James Holmes): Thank you.

Operator: And your next question comes from (John Peters) at UHMS. Your line is open.

(John Peters): Hi, thank you again. With regard to submission of the supported – the supporting documentation is the process, I understand that you might provide a – some type of document that would be a summary is – and then the provider would then fax over or send the information. I mean this obviously is going to be an overwhelming process I would imagine for the MAC.

It just seems to me unwieldy but the – is there going to be any automation or electronic submission with very, very specific guidelines for each indication just to facilitate again to – just to ensure that the patient is not delayed and they're treated appropriately and on time.

Connie Leonard: Well, the documentation can be submitted either through the mail, through the fax or through the esMD system which does allow it to come through electronically. We will certainly discuss with the MACs if there's – if they would like to have a separate cover sheet, the documentation checklist, you know, for you to tell the difference of the, conditions that are covered.

That is certainly one may make it easier for providers and may make it easier for the MAC. So, I just really want the MAC to be able to get right to the information they need as timely as possible, so they can come back within – with the decision to the provider. So, we'll discuss with the MACs what is necessary and we'll update everyone at the next call.

(John Peters): Thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Noel Jett) at Home Health Care. Your line is now open.

(Noel Jett): Yes, could you please review the proposed implementation timeline for the prior authorization project once again?

Connie Leonard: Sure. All we said so far is early calendar year 2015. We do not have these start date as of yet. We will certainly announce in ample time to read it through a federal register notice, through an an open door forum and through our Website but we wanted to get the feedback from the community and to be able to make sure that we're going to implement successfully, so there's no start date as of yet. All we can say right now is early calendar year 2015.

(Noel Jett): Thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from (Helen Gelley) at UHMS. Your line is open.

(Helen Gelley): Hi. Is there a plan in place to confirm the receipt of these medical records?

Connie Leonard: If you submit through the esMD system, there is a receipt notification. If you submit through fax or – again it would only be the receipt from the fax machine and to mail if you submit it through, you know, FedEx or one of the other carriers that provided confirmation of delivery. But if you do submit through an esMD system, there is confirmation of the receipt.

(Helen Gelley): But if you have the – if you sent it by mail for example, could someone put a process in place where the facility with notification that the preauthorization submission has been received?

Connie Leonard: I believe the only way if you submit through mail is for you to get confirmation of the receipt would be confirmation from the mailing entity, either the FedEx or UPS mail or anything else. That would be the only confirmation. I do not believe the MACs, you know, have a process in place to notify providers on any other – through any other mechanism.

We will ask the MACs if they plan to utilize it in portals that they may have out there. I know from their other demonstrations and models, they have the ability to use the portal. I do not know the – if the portal provides any type of response, so we will certainly check all the MACs and update our live presentations and such with the availability.

(Helen Gelley): Will there be a tracking number that one could find out where one's patient's file is in the process?

Connie Leonard: The UTN will not be given until there's a decision and affirmation or a non-affirmation. So, there will not be any tracking number from the perspective of – it's been received and you know where it is; at in the process.

(Helen Gelley): So there will be no way to confirm the 10-day, the 10-business day turnaround time?

Connie Leonard: The only way to confirm the 10-day business turnaround time would be from the date that you have the very confirmation through the day that you got the response back.

(Helen Gelley): OK, thank you.

Connie Leonard: Thank you.

Operator: And your next question comes from the line of (Sue Bill) at Bronson Hospital. Your line is now open.

(Sue Viel): In response to the caller's – the last caller's comments, I would just like to comment that having dealt with the therapy G codes and trying to get prior authorization to go beyond the threshold, our MAC would not accept fax and we did not have a reliable way. Again, it was supposedly a 10-day turnaround.

So, my urging would be that somehow because there are other states that our MAC is dealing with it that are not going to be subject to this, that there be an urgency somehow, that those hospitals that are subject to this model have a way to track this other than everything else that is going into that MAC for everything that has to be tracked or did we get 10 days or whatever.

If this is a special project, I would certainly hope that at the urging of CMS to the MACs, that we have dedicated somehow a line. And I know our MAC, they will not accept pages and pages and this was physical therapy that can be just as voluminous as wound care. So, I don't see our MAC allowing us to even fax to them.

Connie Leonard: So, thank you for your feedback.

(Sue Viel): That's just my comment.

Connie Leonard: I appreciate getting the reference, the past reference because I was unclear as to you know what it is occurred in the past. Obviously, I know there was something, so it's – thank you. I appreciate getting the

(Sue Viel): Yes, I'll have to say the WPS is the therapy cap and they won't do it. I'm pretty sure.

Connie Leonard: Well, I will tell you that, you know, I do understand that there are issues with the therapy cap. I believe that the number of hyperbaric oxygen therapy claims is going to be significantly less than the physical therapy claims and this is, as you said, a special project. So, there is a separate funding for all the MACs to staff accordingly to be able to handle the volume of these projects.

And they will be required to accept mail, fax, or esMD. So, CMS has put certain requirements into place for them and we were working – and we will be working with them on a one to one basis to make sure that they are staffed accordingly to handle the volume in their particular state but we will certainly work with them and ask them questions about, you know, is there a way that they can put in some type of a fax system just because the providers community is a little bit anxious because of some – some of the issues they had in the past.

So we'll – I appreciate the context, you know, regarding those comments and we'll certainly see what we can do, we want to alleviate your fears and this is something we can discuss with WPS. Thank you.

(Sue Viel): Thank you.

Operator: And your next question comes from (Robert Jones) at the Center for Wound Health Care and your line is open.

(Robert Jones): Hello, thank you for the question. At this time, is there any plans to adjust reimbursement to reflect the significant additional documentation submission requirements involved in this project?

Connie Leonard: No, there is certainly no plans to modify the reimbursement rate. The reimbursement rate already includes a portion for allowance of submission of records. CMS could ask for records on every claim that is paid, is it – if it had staff and the time to review them. So, we are just requesting documentation at an earlier time frame. We are not requesting additional documentation or requiring additional effort.

(Robert Jones): Thank you.

Connie Leonard: Thank you.

Operator: And there are no further questions.

Connie Leonard: I do want to remind everyone that if you have further questions or if you can have ideas or scenarios that might require an expedited review or have concerns about any of the six conditions to please e-mail the box that was HBOPA@cms.hhs.gov. We certainly appreciate your feedback and to hear your comments. Thank you.

Operator: And this concludes today's conference call. Participants may now disconnect.

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