Questions and Answers from Open Door Forum: Physicians-January 29, 2020

1. A few questions are, one, will it be one contractor for the whole nation or will they be separate depending on different territories? Will CMS be releasing guidelines or medical necessity rules for each of the procedures since right now there are some of the (MAC)s have LCDs and some don't so it's really kind of a free for all. And then how will the process be done? Will it be fax, will be it phone call, will it be electronic? I think, you know, we want to start orienting our physicians to its happening and we certainly don't want to hear about on June 30 and then have to immediately react.
    a. So with regard to the question about medical necessity, the program doesn't actually make any changes to medical necessity requirements so whatever is in place will be in place as of July 1, 2020. With regard to some of the other questions that you asked, again, we are going to use the website as well as things such as, you know, the open door forums to communicate that more detailed information and so I would just look for that. And certainly we appreciate the need for the information prior to June 30.
2. I also have questions about the new, Prior Auth. Program. So one additional one that wasn't covered in the previous questions was, in the final rule it said that there would be an exemption process. And it just simply says that, you know, some providers may be able to be exempt if they show compliance with Medicare coverage coding and payment rules. Does that process extend to physicians also? Besides to the HOPD Departments? And if so, if you had been under rack audit and demonstrated that you had met 100% compliance, would that make you eligible to be exempt?
    a. Unfortunately have to say, for some of the information that you're asking about, we will need to post it on the Web site as we get into more details about the minutia or the exact mechanics of the exemption process. We are not equating the exemption process to the rack process. I can tell you that. But for the other details, we will, you know, be putting more information onto the Web site. So I would look for that detail about the exemption process in the coming months.
3. I am hopeful that there's someone on the call that can address the review, and verify component of the 2020 Medicare Physician Fee Schedule. That speaks to the fact that a physician, a nurse practitioner, P.A., etcetera, merely needs to document that they reviewed and verified the information on other clinicians or members of quote, "the medical team". As to, does that supersede current requirements for evaluation and managing documentation that is very clear as to what the physician or other billing provider is required to document, uniquely on their own?
    a. There's enough nuance in the policy that we included in the calendar year 2020 Physician Fee Schedule final rule in that area. But if you could, it would actually be really helpful if you could send me an email with your specific question. I don't have the other members of my here with me in the room. And I want to make sure that we get you the right answer.
4. You quickly went through a list of about five services that require the authorization on 71. Could you repeat those for me? And what is the Web address for the site where we will do the authorization?
    a. Yes, so the items are botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation. If you're going to look at the actual final rule, you would actually look to page 61464. I am not going to try and convey the exact Web site address, because it would

literally take me the rest of this call to do it. It is very lengthy. But we have put it in the agenda, and so I would just simply suggest that you go there for it.

5. I was going to ask the same question regarding the Web site. What site do we use to submit the authorizations? I'm looking at my agenda that was forwarded to me, now, and I don't see a link.
    a. So in terms of submitting the Prior Authorization Request, that's what that address is for. More information about the actual mechanics will be forthcoming and placed on that Web page address. I did a quick Web search on CMS Prior Authorization initiatives, and there's a page that pops up pretty quickly, that does discuss prior authorization for certain hospital outpatient department services. So it's pretty easy to find.

6. Which state that the individualized plan of care must specific the care and services necessary to meet the patient specific needs as identified in the comprehensive assessment. Including identification of the responsible disciplines, and the measurable outcomes that the agency anticipates will occur as a result of implementing and coordinating the plan of care. What is CMS' recommendation for those scenarios where a physician orders and documents a need for therapy in the plan of care, but the agency doesn't provide it?
    a. We are currently looking into ways to communicate the agency's stand on this position. Because you're right, the COPs are pretty clear that this, you know, that the services need to be provided in accordance with the plan of care. So we are collaborating with our colleagues across the agency to make sure that any identified issues or vulnerabilities are addressed. And you know, we would put them out, you know, through our usual mechanisms to potentially, MLN. Of course, the open-door forums that we have. You know, the home health and hospice CME open door forums, as well.

7. I wanted to know, what is the appropriate to notify CMS of broken links on the CMS.gov site? So for example, on the National Correct Coding page, all of the links for the January 1, 2020 effective dates, are broken. They appear to be trying to link to the July 2019 files, that aren't there any longer.
    a. The links are now corrected and working.

8. We've been getting a lot of denials from the insurance companies saying that, once a patient is on an inpatient rehab unit, that is their end. And they should return home, and are not authorizing as skilled. They say that's a CMS guideline. Can anybody touch base on that?
    a. When they are medically necessary, Medicare Advantage (MA) plans are required to cover the same services that original Medicare covers. A good starting point regarding SNF eligibility is at https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care So on a case by case basis, you might ask the plan for their specific rationale. If you believe the MA plan has made an incorrect determination, there is an appeals process to follow, and it's important to follow it. See https://www.medicare.gov/claims-appeals/file-an-appeal/appeals-if-you-have-a-medicare-health-plan. A beneficiary may also seek help from the Medicare Beneficiary Ombudsman. See https://www.medicare.gov/claims-appeals/your-medicare-rights/get-help-with-your-rights-protections.

9. But I guess what I'd like to know is, where do I find the answers to these questions that people are asking, that you're saying, oh email them to us. Is that something that will be posted in the future here? And where would I find those answers?
    a. Yes, they will be posted in the near future. There is a process that we go through to get the transcript and the audio and the questions and answers posted. On the agenda is listed - there's a link to where we post then. Our podcasts and transcripts page. It's towards the bottom of the agenda.

10. My question is about a physician ordering labs. This would be in a clinic setting. And the physician, nor no one within our practice, but certainly within his same specialty, has seen that

patient before. Is there guidance as to whether A, first of all, should a physician be ordering labs on a patient before they've seen the patient? And if they do order labs, would that in any way, preclude that physician from billing that first E&M visit then, as a new patient?

a. Yes, it does. So the lab does not have an impact on whether or not the beneficiary is considered to be a new patient. The rules about being a new patient have to do with E&M visits for the same specialty in the same group, in the same three-year period. So to the extent that it's not an E&M, right. So it's a lab or whatever it is. Then it doesn't count against that new patient-ness.

11. But so is it allowable, in Medicare's opinion, that a physician can order labs on a patient that he has not ever seen? And as a pre-visit sort of, to gather information when he hasn't actually seen that patient and is only ordering labs based off of old records or what have you. Is that allowable?

a. There is no prohibition against a provider ordering labs or other tests prior to seeing a beneficiary. As always, all services must be reasonable and necessary.

12. I'm on the Web site right now looking. And is there a Prior Authorization Request Form available on the Web site?

a. And no. Again, we have not actually provided anything regarding the specific mechanics of the process yet, since the process does not begin until July 1 of 2020. So over the next several months we'll be getting more information. And we will, as one vehicle, use that Web page to distribute pertinent information.