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CMS Rules: Direct Supervision Is Gone, Prior Auth Is Here; Documentation Fix Has Limits

By Nina Youngstrom

CMS has given the green light to prior authorization for five types of procedures in an attempt to control "unnecessary increases" in these procedures as part of its Medicare program integrity strategy, according to the final 2020 Outpatient Prospective Payment System (OPPS) regulation[1] announced Nov. 1. There will be more prior authorization in the future, which will challenge hospitals to improve their pre-service coverage analysis. But they got relief from the direct physician supervision requirement for outpatient hospital therapeutic services. CMS shifted it to the more relaxed general supervision standard in the OPPS regulation and did the same thing for certain services, including remote patient monitoring and physician assistants' services, in the final Medicare Physician Fee Schedule (MPFS) regulation,[2] also announced Nov. 1.

Absent from the OPPS final regulation is a controversial provision on price transparency.[3] The proposed regulation would have required hospitals to post the charges they've negotiated with all payers, as well as prices for a subset of "shoppable" services, which many attorneys consider impractical for hospitals. "What was really gratifying was when you look at the comments, providers and payers were in lockstep that payers have the best information for patients on this," says Valerie Rinkle, president of Valorize Consulting. Before hospitals get too sanguine, another version of a price transparency regulation is now at the Office of Management and Budget for review, but its content, timing and fate are unknown. Rinkle is hoping it will capitalize on the portals and other tools that payers already have to share the price of services.

There's a lot of activity on the documentation and evaluation and management (E/M) front in the MPFS regulation. Medicare will continue to pay separately for all office/outpatient visit levels of service, which will have different values to better capture their work relative value units (RVUs). CMS is adopting work RVUs for office/outpatient E/M codes and the new prolonged services add-on code recommended by the RVS Update Committee of the American Medical Association (AMA), and ditching the lowest level CPT code, 99201, for new patients in 2021. At the same time, CMS erased its two-year-old policy for paying non-face-to-face prolonged service codes 99358 and 99359. But a heralded change in the documentation required to support E/M services—allowing physicians the option of using medical decision-making (without exam and history) or time spent with the patient to select the E/M code level—applies only to office/outpatient visits, which limits its usefulness, experts say.

"Whether the changes will achieve CMS's goals may be debated, but CMS certainly appears to be attempting to reduce burden and align Medicare with requirements of other regulations and other state laws," says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kansas.

Will Prior Auth Shift Procedures to ASCs?

CMS stuck to its plan to implement prior authorization for blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation. "We believe that the use of prior authorization in the [outpatient department] context will be an effective tool in controlling unnecessary increases in the volume of covered OPD

services by ensuring that the correct payments are made for medically necessary OPD services, while also being consistent with our overall strategy of protecting the Medicare Trust Fund from improper payments, reducing the number of Medicare appeals, and improving provider compliance with Medicare program requirements."

A prior-authorization denial would extend to all "associated services," including physician services, anesthesiology and/or facility services. However, hospitals can get free from prior authorization if their services are approved 90% of the time over 180 days. CMS will exempt hospitals "once you have proven you can self-govern," Rinkle says.

But pre-service coverage analysis is a blind spot at hospitals. "Many hospitals don't understand you can't code and bill for something if you don't have coverage," she explains. Their order of operations should be: confirm patient eligibility; confirm coverage of the services and that they are medically necessary; and "then and only then do you render them, code them and bill them," because all the recovery audit contractor, targeted probe and educate, and comprehensive error rate testing contractor activities have shown that hospitals lack processes to validate coverage for services and procedures, Rinkle says. She suggests hospital leaders meet with the medical staff and explain how coverage and prior authorization affect all of them. Physicians may have supporting documentation in their clinic records, out of the immediate reach of the hospital. With blepharoplasty, for example, physicians perform the eye tests that show the medical necessity for the procedure because the patients' eyelids block their sight. Hospitals don't do the sight tests again before the procedure, assuming the physicians have done them in their office visit, yet hospitals need the proof of these tests to support medical necessity and also will need them for prior authorization, Rinkle says.

CMS has made it clear it will expand prior authorization "pretty aggressively," Rinkle said. "The only logical response hospitals should have is to get in place a pre-service coverage analysis process tout suite." With an effective process, hospitals shouldn't ask for prior authorization unless they're 100% confident it will be granted, which will accelerate their chance to cross the 90% threshold.

There's also fear of "the unintended consequences or possibly intended consequences" of prior authorization, which could be to shift the site where the five procedures are performed away from hospitals, Rinkle says. After Medicare denies prior authorization for procedures a few times, the ordering physician may start performing them in an ambulatory surgery center, which is not part of the prior authorization process.

In another audit realm, CMS said quality improvement organizations (QIOs) will continue to audit claims for inpatient-only procedures (IPOs) for site of service, but QIOs won't deny claims that aren't compliant with the two-midnight rule for two years after they're removed from the list of IPOs, and hospitals won't be referred to recovery audit contractors for "persistent noncompliance," according to the regulation.

"CMS has realized that doctors are used to ordering inpatient status on all patients undergoing an inpatient-only surgery, and when that procedure is removed from the inpatient-only list, status determination is tricky to figure out," says Ronald Hirsch, M.D., vice president of R1 RCM. "Now they have to decide if inpatient or outpatient is appropriate even though both will be done in the hospital in the same operating room with the same equipment and method. So CMS is giving a two-year grace period for doctors, hospitals, and the auditors to figure out which patients warrant inpatient admission. CMS expects that within two years that ambiguity should be sorted out, but the last two years have really done nothing to help clarify which patients warrant inpatient admission for total knee arthroplasty. But it should be noted that these admissions are not immune from audit and denial for medical necessity of the surgery itself."