VEIN therapy NEWS
OCTOBER/NOVEMBER 2019
VEINTHERAPYNEWS.COM

PRIOR AUTHORIZATION

Best practices to avoid payer denials on vein ablation cases

By Harry G. Curley

Prior Authorization denials can be a problem for vein practices trying to treat patients needing vein ablations. These insidious denials can erode practice revenue and performance if not taken seriously. The matter may become even more critical as CMS contemplates adding prior authorization requirements in the future.

After reviewing our vein practice client performance, we noticed that practices that document and follow Prior Authorization Checklists fared better than those that do not. I discussed with our experienced billing teams the best practices to avoid Prior Auth denials and put together these checklists and key lessons learned below to avoid these unnecessary denials.

The first step is to prepare an overall plan and policy for handling insurance and Prior Authorization matters before any patient procedures are scheduled.

These are the steps I recommend for success:

- Identify and list the plans your practice encounters the most.
- Be proactive and understand the payer policies that cover your procedures. Request specific reimbursement rates from each payer.
- Build an easy-to-follow table for your staff that includes contact information and a list of procedures that require an authorization.
- Train your staff to ensure they are well-versed on the procedures you perform, along with the most commonly associated CPT and ICD-10 CM codes.
- Create a process to ensure all correct information is gathered at the time of scheduling. If any key information is missing, the procedure should be rescheduled.
- Know your denial rate. Due to the fact most payers have a well-defined payment policy for diagnostic and vein treatments, it is not unreasonable to expect a 0 percent denial rate!
- Because most commercial and Medicare payers have varying medical necessity policies, it is important to review each payers' specific policy at least annually.

Then you should create a checklist for your staff to follow for all patient encounters. The key steps include:

- Obtain complete insurance information from the patient and scan the insurance card into EHR/PM.
- Before requesting Prior Authorizations, confirm the patient's insurance eligibility and vein-specific benefits, and that the intended procedure is a covered service.
- Request Prior Authorizations on every procedure, regardless of payer. Payers change their rules frequently and typically don't communicate such changes effectively. It's better to be safe than sorry.

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- Be very specific on Prior Authorization requests. Include the following: Date of service, reason for the procedure including the ICD-10 code and explanation of medical necessity. CPT codes of procedures you plan to perform.
- Ensure that the DOS, ICD-10 and CPT codes approved on the Prior Authorization are identical to those billed. If not, payers will likely deny the claim.
- Choose CPT codes that are specific to laterality, if applicable. Payers may deny the claim if the laterality approved does not match that which is billed.
- Get a hard copy of the Prior Authorization approval from the payer.
- Immediately notify the payer if the actual procedure performed is different than the one authorized and be prepared to explain the reason for the change.
- If necessary, request a Retro Authorization immediately on the date of service. Later attempts are typically unsuccessful.
- Providers must include clear and complete documentation in the provider's note explaining what procedure was performed, how it was performed, and why it was medically necessary. Insurance companies require supporting documentation for denial appeals and it is important that such documents are easily retrievable and prepared for appeals. High quality documentation is typically the most effective weapon a practice has to win in any appeal process.

CHALLENGING PAYERS

Some payers are more challenging regarding Prior Authorization denials for vein ablations.

Anthem, Cigna and UnitedHeathcare present the biggest challenges in attaining Prior Authorizations for ablations, and in appealing such

denials. Pay careful attention to the best practices listed above when treating patients with these insurances.

BEST CHANCES FOR APPROVAL

It is common for payers to require one or more conservative therapies to be attempted before authorizing an ablation procedure. Required conservative therapy policies vary by payer, but most include: Compression therapy, affected leg elevation, anti-inflammatory medication, lifestyle modifications and weight loss.

PREVENTING DENIALS

Attention to documentation can help prevent denials for common vein procedures. The key to approvals is medical necessity. Saphenous vein ablations are performed on patients with symptomatic varicose veins in the lower extremity after conservative therapy fails. It is not enough for the physician to state, for example, "Symptomatic Varicose Veins", without identifying and documenting the associated symptoms such as pain, inflammation or even ulcer.

Every access has got to be documented. Identify the location of the site(s) to be treated – right or left lower extremity – and also name each appropriate vein to be treated, for example, greater, lesser or accessory saphenous vein.

Ultrasound guidance is permitted to be coded along with 36468 Sclero spider veins (rarely needed) and for 36470 and 36471 Sclerotherapy. But, in order for it to be coded, documentation must include the permanent recorded image obtained. **VTN**

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