Disclaimer

• When a third-party payer is involved, the determination of reimbursement for services is the decision of the individual insurance company based on the patient's policy and the third-party payer guidelines. No guidance can adequately address reimbursement issues for the hundreds of insurance payers that exist. Efforts have been made to ensure the information was valid at the date of presentation. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance. Therefore, it is essential that each payer be contacted for their individual requirements.

• The websites listed in this presentation are current and valid as of the date of this presentation. However, webpage addresses and the information on them may change or disappear at any time and for any number of reasons. The attendee is encouraged to confirm or locate any URLs listed here that are no longer valid.

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Federal Register

- Document actions of Federal agencies and forum for public review and comment
- Publications include: Presidential Documents, Rule & Regulations, Proposed Rules and Notices

Hospital Outpatient Prospective Payment System (HOPPS)
Medicare Physician Fee Schedule (MPFS) (Includes QPP)

Proposed vs. Final Rule

Proposed Rule:
• CMS plans, goals, solutions to problems and proposed rulemaking
• Opportunity for public to make comments

Final Rule:
• Final legal effect after consideration of comments
• Opportunity for public to make comments

FINAL RULE

Clinical Decision Support

Be PAMA AUC Prepared
Appropriate Use Criteria

- Introduced in PAMA
- Utilization of Appropriate Use Criteria (AUC) for advanced diagnostic studies
  - CT
  - MR
  - Nuclear Medicine – including PET

Appropriate Use Criteria

CMS can only approve the AUC that are developed or endorsed by provider-led entities (PLEs)

- Must be evidence based
- Listing is on CMS’s website

Once a PLE is “qualified” all of the AUC developed or endorsed by that PLE are considered to be “specified AUC” for the purposes of the requirements.

Clinical Decision Support

8 priority clinical areas
- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- Low back pain
- Shoulder pain (to include suspected rotator cuff)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain
Clinical Decision Support

- Ordering physician must access AUC through a Clinical Decision Support Mechanism (CDSM)
- CDSM is an electronic portal
  - Module in an EHR
  - Web-based system
- CDSM will pull information about the patient from the EHR and/or the ordering physician will enter the information and immediate feedback will be provided re: appropriateness of exam

Approved Support Mechanisms

Clinical Decision Support

- Requirement is that AUC must be consulted
- Radiologists will not be exempt
- Does not apply to inpatient, certain emergency studies or to ordering physicians who qualify for a hardship exception
  - There are no hardships for furnishing professionals
  - CAHs are exempt
- Ordering professionals must communicate the results of the consultation to the imaging provider
  - Facility & Radiologist
Appropriate Use Criteria

Eventually outliers will be identified.

CMS will require prior authorization for any advanced imaging studies ordered by outlier physicians.

Implementation Timeline

- Original implementation was January 1, 2017
- CDS delayed in 2016-2018 Final Rules
- New implementation date of January 1, 2020 – testing period of 1 year
  - Mandatory implementation date of 1/1/21
- Voluntary reporting period of 7/2018 – 12/2019
  - Early adopters can begin to submit data to CMS
  - Identifier will not be ready yet so CMS created the QQ modifier

Voluntary Reporting

QQ modifier

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QQ</td>
<td>Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional</td>
</tr>
</tbody>
</table>

Only indicates that AUC was consulted – not the results.
Implementation

2020 will be a testing year

Medicare will pay regardless of whether or not AUC recommends the study

Beginning January 1, 2021 payment will be denied if the furnishing professionals’ claims lack the required AUC information

New Reporting Requirements

- Required beginning 1/1/2020
- 1 G-code required on the claim per mechanism
- Modifiers to be assigned at the CPT code level indicating adherence to the utilized AUC
  - Adhered, Not Adhered, Not applicable
- Many operational concerns with these requirements
- How will you communicate this information to the imaging providers?

New Modifiers

<table>
<thead>
<tr>
<th>HCPCS Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MA</td>
<td>Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition</td>
</tr>
<tr>
<td>MB</td>
<td>Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access</td>
</tr>
<tr>
<td>MC</td>
<td>Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues</td>
</tr>
<tr>
<td>MD</td>
<td>Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances</td>
</tr>
<tr>
<td>ME</td>
<td>The order for this service adheres to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional</td>
</tr>
<tr>
<td>MF</td>
<td>The order for this service does not adhere to the appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional</td>
</tr>
<tr>
<td>MG</td>
<td>The order for this service does not have appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional</td>
</tr>
<tr>
<td>MH</td>
<td>Unknown if ordering professional consulted a clinical decision support mechanism or level 1 code for this service, related information was not provided to the furnishing professional as applicable</td>
</tr>
</tbody>
</table>
### New G-Codes

<table>
<thead>
<tr>
<th>G-Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1000</td>
<td>Clinical Decision Support Mechanism: Applied Pathways, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1001</td>
<td>Clinical Decision Support Mechanism: eviCore, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1002</td>
<td>Clinical Decision Support Mechanism: MedCurrent, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1003</td>
<td>Clinical Decision Support Mechanism: Medicalis, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1004</td>
<td>Clinical Decision Support Mechanism: National Decision Support Company, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1005</td>
<td>Clinical Decision Support Mechanism: National Imaging Associates, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1006</td>
<td>Clinical Decision Support Mechanism: Test Appropriate, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1007</td>
<td>Clinical Decision Support Mechanism: AIM Specialty Health, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1008</td>
<td>Clinical Decision Support Mechanism: Cranberry Peak, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1009</td>
<td>Clinical Decision Support Mechanism: Sage Health Management Solutions, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1010</td>
<td>Clinical Decision Support Mechanism: Stanson, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
<tr>
<td>G1011</td>
<td>Clinical Decision Support Mechanism, qualified tool not otherwise specified, as defined by the Medicare Appropriate Use Criteria Program</td>
</tr>
</tbody>
</table>

CMS has also provided the full list of HCPCS advanced imaging procedure codes which are included in the AUC program. This can be reviewed in the MLN Matters MM11268, [https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticles/Downloads/MM11268.pdf](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticles/Downloads/MM11268.pdf).

### Steps to Take...

- What is the current plan?
  - Already implemented?
  - In process?
  - Not on the radar?!

- Understand the current processes
  - Scheduled outpatient
  - Map out to ensure everyone is on the same page

### What do we Know?

- Effective 1/1/20 imaging providers (including Oncologists that own and perform diagnostic studies) must report a G code at the claim level and a modifier at the line item level for designated exams:
  - Multiple G codes may be on the same claim

- Facilities cannot perform this for the referring physicians
  - Referring physicians can have their own clinical staff perform at their direction
Unknows

Additional Questions...

- Will CDS be required when Medicare is the secondary payer?
- How does the CDS consultation requirement apply to observation patients?
- What will happen to modifier MH in 2021?

Next Steps

- Specifically clarify your organization’s issues and concerns
- Have a clear plan to address
- Learn from others – good, bad & ugly
- Watch for more CMS updates and incorporate into your plans
Select Body Area + Reason

Not All Combinations Exist

- Requesting a head study for lung cancer
Switch to Modality Mode

Opportunity for Free Text
- Comments are allowed – but not required

Accept To Receive CDSN
- This is the # that will potentially ultimately be submitted with the claim
  - Will be linked to this specific exam within the master CMS database/registry
Medically Reasonable / Necessary

- Medical Record must demonstrate
  - “… support (of) the intensity and frequency of the E/M service met but that it did not exceed the patient’s clinical needs.”
  - “…the patient’s condition is the key factor in determining medical necessity.”

Where’s the Money?

- Incorrectly or mistakenly coding a medical service will likely lead to an uptick in claims denials, so healthcare organizations should regularly train clinical staff on ICD-10 coding updates and encourage front-end staff to communicate with clinicians if there are documentation issues.

Incomplete Information – Unspecified

- CMS: LCDs and NCDs that contain ICD-10 codes for right side, left side or bilateral do not allow for unspecified side. (i.e., will be denied)
- Conditions frequently assigned unspecified codes

<table>
<thead>
<tr>
<th>Condition</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and drug use</td>
<td>Alzheimer's</td>
</tr>
<tr>
<td>Alcohol and drug use</td>
<td>Arthritis</td>
</tr>
<tr>
<td>Asthma</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>Cardiomyopathy</td>
<td>Atrial flutter</td>
</tr>
<tr>
<td>Depression</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Malignancies</td>
<td>Intestinal obstruction</td>
</tr>
<tr>
<td>Malignancies</td>
<td>Non-pressure ulcers</td>
</tr>
<tr>
<td>Malignancies</td>
<td>Pressure ulcers</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>Respiratory failure</td>
</tr>
<tr>
<td>Sepsis</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Trauma</td>
<td>Traumatic injuries</td>
</tr>
</tbody>
</table>
Evaluation & Management

- E/M visits account for approximately 40% of allowed charges for MPFS services, 20% are office/outpatient E/M visits
  - Considerable financial aspect for CMS
- CY 2018 CMS sought comments and feedback on how to change
- Longstanding stakeholder comments that 1995 & 1997 E/M guidelines are outdated and administratively burdensome
- CMS proposed changes to office/outpatient E/M codes only
  - New patient visit codes (99201-99205)
  - Established patient visit codes (99211-99215)
- CMS proposed several changes not all finalized for 2019
  - 2021 is the big year for changes

E/M Guidelines 2019 Changes

- Reducing Duplication of E/M Documentation
- Teaching Physician E/M Documentation Changes
- Brief Communication Technology-based Service New HCPCS Code

Reducing Duplication of E/M Documentation

- New & established patients no need to re-enter chief complaint & history IF already entered by staff or beneficiary
- Key history and exam for established patients – only those changed or new – still conduct medically necessary inquiries and exams for visit
- Must indicate info was reviewed in medical record by practitioner for any non-repeated documentation
**Teaching Physician E/M Changes**

**2018**
- Medical record must document that the teaching physician was present at the time the service is furnished.
- Teaching physician must document extent of participation in the review and direction of services furnished to each beneficiary.

**2019**
- Medical record must document teaching physician was present during procedures and E/M services and may be documented by physician, nurse or resident by notes in medical record.
- Medical record must document extent of teaching physician’s participation in review and direction of services furnished and the extent can be demonstrated by the notes in medical record made by physician, resident or nurse.

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**Virtual Check-in – 2019 New**

- Brief communication technology-based service (Virtual Check-in)
- Based on new technologies, preferences of patients and physicians for communication
- Brief check-in to determine if office visit or another service is needed
- Utilized correctly, it can prevent unnecessary office visits, resulting in reduced costs and waste
- HCPCS code G2012 – New 2019

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**HCPCS Code G2012 Definition**

Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
Documentation Brief Check-in

- Must obtain verbal consent of patient to bill service to CMS and note in medical record
- If brief check-in originates from related E/M provided within previous 7 days by same physician, not separately billable
- If brief check-in leads to E/M by same physician, not separately billable part of pre or post time
- Only available to established patients to that physician
- No service specific documentation requirements
- Must be medically necessary and reasonable

Guidelines for HCPCS G2012

Must be medically necessary for check-in, CMS to closely monitor for possible future limitations

Modes of technology include - audio-only real-time phone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission

Code requires direct interaction between patient and billing practitioner

Phone calls with only clinical staff not billable with G2012

E/M Guidelines 2021 Changes

- Select from 1 of 3 Frameworks to document outpatient new & established patient visits
- Add-on code for specialized complexity
- Add-on code for prolonged services
Medically Appropriate History/PE

(A) Removing history and examination as key components for selecting the level of E/M service, but adding the requirement that a medically appropriate history and/or examination must be performed in order to report codes 99202-99215;

Read full summary for additional details on changes to E/M codes 99202-99215.

MDM or Time

(B) Making the basis for code selection either the level of medical decision making (MDM) performed or the total time spent performing the service on the day of the encounter;

MDM v. Time Revisions

(C) Changing the definition of the time element from typical face-to-face time to total time spent on the day of the encounter, changing the amount of time associated with each code; revision of the MDM elements as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Medical Decision Making (MDM)</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019</td>
<td># of diagnoses or management options</td>
<td>Risk of complications and mortality</td>
</tr>
<tr>
<td></td>
<td># of problems addressed</td>
<td>Typical time (with summary of face-to-face counseling/coordination of care)</td>
</tr>
<tr>
<td>2021</td>
<td># of problems addressed</td>
<td>Risk of complications and mortality</td>
</tr>
<tr>
<td></td>
<td>Amt and/or complexity of data to be reviewed and analyzed</td>
<td>Total time</td>
</tr>
</tbody>
</table>
Originally Estimated 2021 Payment Rates – Changed in 2020 FY

<table>
<thead>
<tr>
<th>Complexity Level under CPT®</th>
<th>Visit Code</th>
<th>Visit Code with Either Primary or Specialized Care Add-on Code*</th>
<th>Visit Code with New Extended Services Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$75</td>
<td>$143</td>
<td>$197</td>
</tr>
<tr>
<td>Level 3</td>
<td>$110</td>
<td>$150</td>
<td>$197</td>
</tr>
<tr>
<td>Level 4</td>
<td>$167</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$211</td>
<td>$212</td>
<td></td>
</tr>
<tr>
<td>Established Patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>$74</td>
<td>$103</td>
<td>$157</td>
</tr>
<tr>
<td>Level 4</td>
<td>$159</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$168</td>
<td>$168</td>
<td></td>
</tr>
</tbody>
</table>

E/M Add-on Codes 2021

<table>
<thead>
<tr>
<th>Code</th>
<th>Specialized Complexity</th>
<th>Applies to</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>G09X</td>
<td>Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, cardiology or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)</td>
<td>Anyone who performed a visit and as part of the visit discussed a treatment plan etc. related to the additional specialties identified by the code</td>
<td>Oncologist sees patient discusses cancer diagnosis and the treatment plan including surgical and chemotherapy options. Physician reports the specialty add-on code and physician’s specialty reported on claim form and medical record supports diagnosis and clinician’s assessment and plan</td>
</tr>
<tr>
<td>GPRO1</td>
<td>Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service, 30 minutes (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)</td>
<td>Only billable with level 2-4 visit codes</td>
<td></td>
</tr>
</tbody>
</table>
**AMA CPT® Editorial Panel Updates CY 2020 & 2021**

**Name** - Office or Other Outpatient Services

- **Code #** - D99201 ▲99213 ▲99202 ▲99214 ▲99203 ▲99215 ▲99204 ▲99205 ▲99211 ▲99212

- **Effective Date** - January 1, 2021

- **Description of Editorial Panel Action** –
  - Accepted deletion of code 99201
  - Revision of codes 99202-99215

Modifiers 59 and X Update

Modification of the MCS Claims Processing System Logic for Modifier 59, XE, XS, XP, and XU Involving the National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) Column One and Column Two Codes, Effective July 1, 2019


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MM11168

**PROVIDER TYPE AFFECTED**

This MLN Matters® Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services to Medicare beneficiaries.

**PROVIDER ACTION NEEDED**

CR 11159 informs MACs about changes to National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) edits which consist of column one and column two codes. Make sure that your billing staffs are aware of these changes.

**BACKGROUND**

Modifiers 59, XE, XS, XP, and XU are among the NCCI associated modifiers. The Multi-Carrier System (MCS) currently requires that modifiers 59, XE, XS, XP, or XU be appended to the column two code of a PTP edit to bypass the edit. With the implementation of CR 11159, Medicare will allow modifiers 59, XE, XS, XP, or XU on column one and column two codes to bypass the edit.

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MM11296

- Ten (10) new HCPCS codes will be payable for Medicare, effective for claims with dates of service on or after July 1, 2019

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>J1444</td>
<td>Fe pyr cit pow 0.1 mg iron</td>
</tr>
<tr>
<td>J7200</td>
<td>Inj. jvi 1 1u</td>
</tr>
<tr>
<td>J7677</td>
<td>Ravelenacin inh non-com 1mg</td>
</tr>
<tr>
<td>J9030</td>
<td>Bcg live intravesical 1mg</td>
</tr>
<tr>
<td>J9036</td>
<td>Inj. belaplatin/bendamustine</td>
</tr>
<tr>
<td>J9355</td>
<td>Inj. herceptin hycleta, 10mg</td>
</tr>
<tr>
<td>Q5112</td>
<td>Inj ontruzant 10 mg</td>
</tr>
<tr>
<td>Q5113</td>
<td>Inj herzuma 10 mg</td>
</tr>
<tr>
<td>Q5114</td>
<td>Inj ogtvri 10 mg</td>
</tr>
<tr>
<td>Q5115</td>
<td>Inj rituxim-atls bio 10 mg</td>
</tr>
</tbody>
</table>
MM11296 cont.

- HCPCS code J9031 (Bcg (intravesical) per instillation), no longer reimbursed, effective for claims with dates of service on or after July 1, 2019.
- The long and short descriptors for HCPCS code J9355 will be modified, effective for claims with dates of service on or after July 1, 2019,
  - J9355 Short Descriptor: Inj trastuzumab excl biosimi
  - J9355 Long Descriptor: Injection, trastuzumab, excludes biosimilar, 10 mg

Questions

Thank you

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Melody.Mulaik@CodingStrategies.com