




## Issues to Watch

Overview of Hot Topics in Health Care Compliance



**Marie Wagner, CHC, CHRC**  
Sr. Corporate Compliance Coordinator

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## The Queen's Health Systems




**The Queen's Medical Center**

- Level 1 Trauma Center located in downtown Honolulu
- 575 acute beds
- Admissions 24,906
- ER visits 65,854
- OP visits 314,351




**Molokai General Hospital**

- Critical Access Hospital located in Kaunakakai on Molokai
- 15 bed rural health care facility
- Admissions 95
- ER visits 5,278
- OP visit 18,226



**The Queen's Medical Center - West O'ahu**

- Community hospital located in 'Ewa
- 80 acute beds
- Admissions 4,597
- ER visits 52,850
- OP visits 44,019



**North Hawai'i Community Hospital**

- Rural acute care in Waiimea on Hawai'i
- 35 acute beds
- Admissions 1,707
- ER 14,220 visits
- OP 55,431
- Home Health affiliate

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## The Queen's Health Systems




**Diagnostic Laboratory Services, Inc.**

- Locally owned and operated commercial laboratory
- Over 40 locations statewide




**Queen's Insurance Exchange, Inc.**

- Provides liability insurance coverage for QHS and affiliates




**Queen's Clinically Integrated Physician Network**

- Physician-led network transforming health care by developing and adopting clinical best practices




**Queen Emma Land Company**

- Manages and enhances the income-generating potential of lands left to The Queen's Hospital by Queen Emma, and additional properties owned by QHS




**CareResource Hawai'i**

- Delivers home based and community health care, serving Oahu, Molokai, Maui and Hawaii Island.




**Queen's 'Akoako, LLC**

- Accountable Care Organization
- Quality improvement, knowledge and support, and successful payment models




**Queen's Development Corporation**

- Manages Queen's Health Care Centers with 7 locations on Oahu, Big Island and Kauai; POBs, OP pharmacies & parking garages



**Hamamatsu/Queen's PET Imaging Center, LLC**

- Maintains and operates a positron emission tomography (PET) research and diagnostic imaging center (the PET Center)



**Queen's MSSP ACO, LLC**

- Accountable Care Organization: Medicare program created to encourage health care providers and entities to work together to improve patient health and reduce unnecessary costs of care

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## Objectives

"Rapid fire" overview of hot topics that keep showing up with regulators and within the enforcement community




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## Agenda

- New Types of MAC Reviews
- Telemedicine and upcoming changes
- Continued scrutiny of device credits
- Provider-Based location challenges
- 340B program changes
- More appearances of Shared Decision Making
- And Others!




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## NEW TYPES OF MAC REVIEWS

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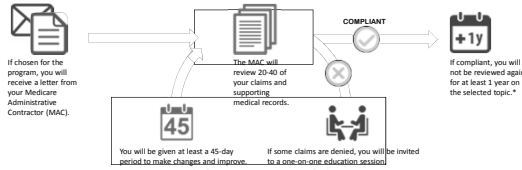
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## Targeted Probe & Educate (TP&E)

### HOW DOES IT WORK?



\*MACs may conduct additional review if significant changes in provider billing are detected.

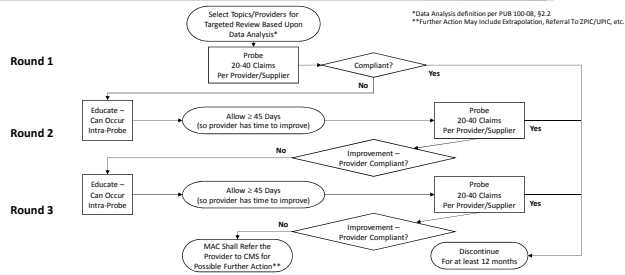
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## TP&E



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## TP&E

### WHAT ARE SOME COMMON CLAIM ERRORS?

- Missing or incomplete orders or certifications/recertification
- Expired orders or certifications/recertifications
- Signature missing on order, certification/recertification, encounter note
- Documentation does not meet medical necessity (NCD, LCD, Conditions of Payment)

### WHAT IF THERE IS NO IMPROVEMENT?

CMS has reported that the majority of those that have participated in the TPE process increased the accuracy of their claims. However, failure to improve after 3 rounds of TPE will be referred to CMS for next steps.

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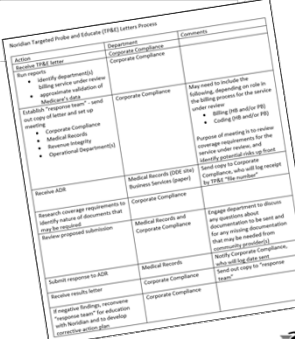
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## TP&E

Corporate Compliance Department

TP&E letter received by Compliance Department

Medical Records  
Revenue Cycle  
Operational (Clinical) Departments



**TP&E Letter Process**

Action	Department	Comments
Receive TP&E letter	Corporate Compliance	
Identify Department(s)	Corporate Compliance	
Identify service under review	Corporate Compliance	
Appropriate utilization of NDC/HCPCS codes	Corporate Compliance	
Establish "request letter" and language of letter and set up meeting	Corporate Compliance	May need to include the following, depending on the service under review: <ul style="list-style-type: none"> <li>Billing CPT and/or HCPCS</li> <li>Coding ICD and/or ICD-9</li> </ul>
Corporate Compliance	Medical Records (EHR and Business Systems Support)	Purpose of meeting is to review coverage requirements, and identify potential compliance issues with the TP&E letter.
Medical Records (EHR and Business Systems Support)	Medical Records and Corporate Compliance	Engage department to discuss any documentation that may be needed for the ongoing investigation (that may be needed from the provider's perspective).
Research coverage requirements to identify nature of documents that support the claim	Medical Records and Corporate Compliance	Notify Compliance Department of any issues identified.
Review proposed submission	Medical Records	Send and reply to "request letter".
Submit response to ADA	Corporate Compliance	
Review results letter	Corporate Compliance	
Finalize findings, recommend "response letter" for education with Noridian and to develop corrective action plan	Corporate Compliance	

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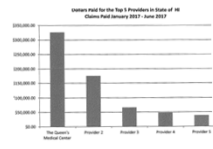
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## Provider Billing Analysis Letters (PBAL)

**BASED ON DATA ANALYTICS**  
**EDUCATIONAL IN NATURE**



**Amount Paid for the Top 5 Providers in State of HI (FY2014 to FY2017)**

Provider	FY2014	FY2015	FY2016	FY2017
Provider 1	\$2,000,000	\$1,800,000	\$1,600,000	\$1,400,000
Provider 2	\$1,500,000	\$1,300,000	\$1,100,000	\$900,000
Provider 3	\$1,000,000	\$800,000	\$700,000	\$600,000
Provider 4	\$800,000	\$600,000	\$500,000	\$400,000
Provider 5	\$600,000	\$400,000	\$300,000	\$200,000

Noridian Healthcare Solutions, LLC (Noridian) is the Jurisdiction E (JE) Medicare Administrative Contractor (MAC). In order to fulfill our contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Noridian Medical Review develops a strategy using data analysis to aid in improper payment rate reduction. Noridian Medical Review performs routine data analysis to evaluate for billing utilization changes or patterns and initiates one-on-one educational letters. This letter is strictly educational in nature.

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## PBAL

**BRIEF OVERVIEW OF SPECIFIC CPT/HCPCS CODE COVERAGE REQUIREMENTS**  
**RECOMMENDATION TO SELF-REVIEW TO DETERMINE SUFFICIENT DOCUMENTATION**  
**SUMMARY OF ACTIONS TO TAKE IF DEFICIENCIES DISCOVERED**

Noridian encourages you to review the requirements for this service and evaluate for appropriateness. Please note, this letter is not a reflection of your competence as a health care professional or of the quality of care you provide to your patients. You are receiving this letter based on data analysis of billing patterns by your PTAN.

**Summary**  
In summary, Noridian monitors provider billing patterns on an ongoing basis. Providers are encouraged to review Medicare Regulations to determine if documentation supports Medicare reimbursement for services which are billed in an appropriate manner. Additionally, Providers/Suppliers may consider the following actions:

- Submit voluntary refunds to Medicare for any identified overpayments.
- Provide education regarding error(s) noted to applicable staff members.
- Review and update internal controls or processes if any errors are identified.

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## Telemedicine – Medicare (OIG Audit)

**Department of Health and Human Services  
OFFICE OF  
INSPECTOR GENERAL**

**CMS PAID PRACTITIONERS FOR  
TELEHEALTH SERVICES THAT  
DID NOT MEET MEDICARE  
REQUIREMENTS**

Report issued at the request of the Office of the Inspector General, HHS, in  
accordance with the Inspector General Act of 2008, as amended.

**Steve L. Saper  
Inspector General**  
April 2018  
4/10/18

**How OIG Did This Review**  
We reviewed 191,118 Medicare paid distant-site telehealth claims, totaling \$13.8 million, that did not have corresponding originating-site claims. We reviewed provider supporting documentation for a stratified random sample of 100 claims to determine whether services were allowable in accordance with Medicare requirements.

**What OIG Found**  
CMS paid practitioners for some telehealth claims associated with services that did not meet Medicare requirements. For 69 of the 100 claims in our sample, telehealth services met requirements. However, for the remaining 31 claims, services did not meet requirements. Specifically:

- 24 claims were unallowable because the beneficiaries received services at nonrural originating sites,
- 7 claims were billed by ineligible institutional providers,
- 8 claims were for services provided to beneficiaries at unauthorized originating sites,
- 2 claims were for services provided by an unallowable means of communication,
- 1 claim was for a noncovered service, and
- 1 claim was for services provided by a physician located outside the United States.

We estimated that Medicare could have saved approximately \$3.7 million during our audit period if practitioners had provided telehealth services in accordance with Medicare requirements.

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## Telemedicine – Medicare (OIG Audit)

**Review of Medicare Payments for Telehealth Services**

Medicare Part B covers expenses for telehealth services on the telehealth list when those services are delivered via an interactive telecommunications system, provided certain conditions are met (42 CFR § 410.770). To support rural access to care, Medicare pays for telehealth services provided through live, interactive videoconferencing between a beneficiary located at a rural originating site and a practitioner located at a distant site. An eligible originating site must be the practitioner's office or a specified medical facility, not a beneficiary's home or office. We will review Medicare claims paid for telehealth services provided at distant sites that do not have corresponding claims from originating sites to determine whether those services met Medicare requirements.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
October 2017	Centers for Medicare & Medicaid Services	Review of Medicare Payments for Telehealth Services	Office of Audit Services	W-00-16-35790; A-05-16-00058	2018

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## Telemedicine – Medicare (Recent Changes)

Elimination of GT modifier for telehealth services

Effective January 1, 2018



- GT modifier no longer to be used on claims for professional services provided by telehealth (was used to signify all telehealth requirements met)
  - Exception: GT modifier still required for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims
- New place of service code 02 established to indicate telehealth services being billed meet all requirements

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## Telemedicine – Medicare (Upcoming Changes)

Bipartisan Budget Act of 2018

Effective 2019:

- Telestroke services – expanded eligible geographic and originating site
- Home dialysis patient physician visits (with in-person visits at specified intervals)

Effective 2020:

- Allowing Medicare Advantage plans to expand telehealth coverage as part of the basic benefits package
- Providers participating in certain Accountable Care Organizations (ACOs) may offer telehealth services to patients in their homes

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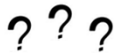
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## Telemedicine – Medicare (Proposed Changes)

Medicare Physician Fee Schedule 2019 Proposed Rule

Use of “virtual technologies” – not technically telemedicine



- Virtual Check-Ins – brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient’s condition necessitates an office visit
- Evaluation of Asynchronous Images and Video – review of recorded video and/or images captured by a patient in order to evaluate the patient’s condition and determine whether an office visit is necessary
- Peer-to-Peer Internet Consultations – telephone, internet or EHR consultations with treating physician without patient face-to-face contact for specific expertise

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## Telemedicine – Hawaii Parity

**§431:10A-116.3 Coverage for telehealth.** (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No accident and health or sickness insurance plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the insurer, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

**§432:1-601.5 Coverage for telehealth.** (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No mutual benefit society plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollee or subscriber, the mutual benefit society, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

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## Telemedicine – Hawaii Parity

**§432D-23.5 Coverage for telehealth.** (a) It is the intent of the legislature to recognize the application of telehealth as a reimbursable service by which an individual shall receive medical services from a health care provider without face-to-face contact with the health care provider.

(b) No health maintenance organization plan that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient as a prerequisite for payment for services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services were provided. The coverage required in this section may be subject to all terms and conditions of the plan agreed upon among the enrollees or subscriber, the health maintenance organization, and the health care provider.

(c) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

**[§346-59.1] Coverage for telehealth.** (a) The State's Medicaid managed care and fee-for-service programs shall not deny coverage for any service provided through telehealth that would be covered if the service were provided through in-person consultation between a patient and a health care provider.

(b) Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

(c) There shall be no geographic restrictions or requirements for telehealth coverage or reimbursement under this section.

(d) There shall be no restrictions on originating site requirements for telehealth coverage or reimbursement under this section.

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CORPORATE COMPLIANCE THE HAWAIIAN HEALTH SYSTEM



## CONTINUED SCRUTINY OF DEVICE CREDITS

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## Continued Scrutiny of Device Credits

Department of Health and Human Services  
OFFICE OF  
INSPECTOR GENERAL

**HOSPITALS DID NOT ALWAYS COMPLY  
WITH MEDICARE REQUIREMENTS FOR  
REPORTING COCHLEAR DEVICES  
REPLACED WITHOUT COST**

For the 116 incorrectly billed claims we identified, hospitals received \$2,685,588 in Medicare overpayments. These overpayments occurred because hospitals did not have controls to identify and report no-cost replacements they received from cochlear device manufacturers.

Reported under the report on the implementation of the  
HHS OIG's findings



Office of the Inspector General  
Department of Health and Human Services  
November 2014  
HHS-10-000000000000000000

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## Continued Scrutiny of Device Credits

Department of Health and Human Services  
OFFICE OF  
INSPECTOR GENERAL

### HOSPITALS DID NOT COMPLY WITH MEDICARE REQUIREMENTS FOR REPORTING CERTAIN CARDIAC DEVICE CREDITS

All 296 payments reviewed for recalled cardiac medical devices did not comply with Medicare requirements for reporting manufacturer credits. Medicare contractors incorrectly paid hospitals \$7.7 million for cardiac device replacement claims rather than the \$3.3 million they should have been paid, resulting in potential overpayments of \$4.4 million.

Reported under the Hospital Care Audit by the Office of Public Affairs of the Department of Health and Human Services



Office of Inspector General  
U.S. Department of Health and Human Services  
Washington, D.C. 20180

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## Continued Scrutiny of Device Credits

Stratum	Risk Area	Claims in Sampling Frame	Claims in Sample
1	Elective Procedures Billed as Inpatient	2,407	30
2	Inpatient Claims Billed with High Severity Level DRG Codes	1,027	30
3	IRF Claims	363	30
4	Inpatient Manufacturer Credits for Replaced Medical Devices	41	41
5	Inpatient Claims with Same Day Discharge & Readmissions	8	8
6	IPP Emergency Department Adjustments	5	5
7	Outpatient Claims Billed with Modifier -59	639	30
8	Outpatient Claims Billed with Modifier -25	1,616	30
9	Outpatient Manufacturer Credits for Replaced Medical Devices	20	20
10	Outpatient Evaluation and Management Services Billed at a Higher Level Than Physician	236	30
11	Outpatient Claims Billed for the Drug Herceptin	5	5
12	Outpatient IMRT Claims	2	2
Total Sampled Claims		6,369	261

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## Continued Scrutiny of Device Credits

Regulatory citation: 42 CFR 412.89

### §412.89 Payment adjustment for certain replaced devices.

(a) *General rule.* For discharges occurring on or after October 1, 2007, the amount of payment for a discharge described in paragraph (b) of this section is reduced when—

- (1) A device is replaced without cost to the hospital;
- (2) The provider received full credit for the cost of a device; or
- (3) The provider receives a credit equal to 50 percent or more of the cost of the device.

(b) Discharges subject to payment adjustment. (1) Payment is reduced in accordance with paragraph (a) of this section only if the implantation of the device determines the DRG assignment.

(2) CMS lists the DRGs that qualify under paragraph (b)(1) of this section in the annual final rule for the hospital inpatient prospective payment system.

(c) *Amount of reduction.* (1) For a device provided to the hospital without cost, the cost of the device is subtracted from the DRG payment.



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## Continued Scrutiny of Device Credits

Be sure you are reporting device credits properly when submitting claims to Medicare

Coding/Billing Issue	Inpatient	Outpatient
What Condition Code do I use?	<b>49</b> —replaced within lifecycle <b>50</b> —recalled and replaced	<b>49</b> —replaced within lifecycle <b>50</b> —recalled and replaced <b>53</b> —initially placed in clinical trial
What Value Code and amount do I use?	<b>FD</b> —dollar amount of the price reduction or credit	<b>FD</b> —dollar amount of the price reduction or credit
How do I report a no-cost item charge?	If your system allows it, use <b>\$0.00</b> If \$0.00 is not allowed, use <b>\$1.00</b>	If your system allows it, use <b>\$0.00</b> If \$0.00 is not allowed, use <b>\$1.00</b>

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CORPORATE COMPLIANCE THE CHANGING HEALTHCARE SYSTEM

## Continued Scrutiny of Device Credits

IMPORTANT POINT:

In OIG audits, it is important to note that they have focused not only on credits received, but also credits not pursued



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## PROVIDER-BASED LOCATION CHALLENGES

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## Provider-Based Location Challenges

Bipartisan Budget Act of 2015, Section 603

- Effective 1/1/2017, no off-campus hospital outpatient department may bill under OPPS unless:
  - Dedicated Emergency Department
  - Excepted/grandfathered**



Excepted/grandfathered (must meet one of the below criteria):

- Provided and billed under OPPS for covered outpatient services prior to 11/2/2015
- On campus or within 250 yards of the main hospital or remote location of a multi-campus hospital

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## Provider-Based Location Challenges

Due to comments regarding billing challenges for hospitals, CMS did allow hospitals to continue to bill on the institutional claim forms (UB), allowing revenue to appear associated with the appropriate cost center

- Use modifier "PN" to designate services at non-excepted locations
- Rate paid is much lower than OPPS rate
  - 2017: 50% of OPPS rate for same services at excepted locations
  - 2018: reduction to 40% of OPPS rate
  - 2019 (proposed): remains at 40% of OPPS rate

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## 340B PROGRAM CHANGES

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## 340B

The 340B Drug Pricing Program was established by Congress in 1992, with a goal of reducing the price of covered drugs for certain participating entities which, in turn, provides additional resources (by money saved) to serve underserved and indigent patients.

A recent Congressional reports notes, however:

“Congress did not clearly identify the intent of the program and did not identify clear parameters, leaving the statute silent on many important program requirements.”



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CORPORATE COMPLIANCE THE CHAIRMAN'S HEALTH SYSTEM

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## 340B

The proposed “340B Program Omnibus Guidance “ (“Mega-Guidance”) was issued on 8/25/2015 and included clarification on some of the areas with apparent regulatory deficiencies, including but not limited to:

- Definition of “patient”
- Registration of off-campus “child sites”
- Scope of eligible drugs
- Contract pharmacy arrangements

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CORPORATE COMPLIANCE THE CHAIRMAN'S HEALTH SYSTEM

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## 340B

In part, due to the volume of comments received, the issuing agency delayed finalizing the guidance.

On 1/20/2017, the new administration withdrew the proposal as part of the overall regulatory freeze.



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CORPORATE COMPLIANCE THE CHAIRMAN'S HEALTH SYSTEM

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## 340B

One thing that did change recently in the 2018 OPPS Final Rule was a downward adjustment of Medicare payment for drugs purchased through the 340B program to Average Sales Price (ASP) minus 22.5% from the prior rate of ASP plus 6%.

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## MORE APPEARANCES OF SHARED DECISION MAKING

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## Shared Decision Making

Affordable Care Act, Section 3506:  
Program to Facilitate Shared Decision Making  
January 5, 2010



CMS Beneficiary Engagement and Incentives (BEI) Models  
Shared Decision Making (SDM) Model

December 8, 2016

- Applies to Accountable Care Organizations (ACO)
- *Hospitals engaged through requirements of NCDs*

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CORPORATE COMPLIANCE



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## NCD 210.14 Lung Cancer Screening with Low Dose Computed Tomography

NCD Updated January 24, 2017  
Effective February 5, 2015

### B. Nationally Covered Indications

#### Counseling and Shared Decision Making Visit

Before the beneficiary's first lung cancer LDCT screening, the beneficiary must receive a counseling and **shared decision making visit** that meets all of the following criteria, and is appropriately documented in the beneficiary's medical records:

<...>

Must include all of the following elements:

<...>

**Shared decision making**, including the use of one or more decision aids, to include benefits and harms of screening, follow-up diagnostic testing, over-diagnosis, false positive rate, and total radiation exposure

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## More Shared Decision Making in NCDs

- NCD 20.34 Percutaneous Left Atrial Appendage Closure (LAAC)  
Effective 2/8/2016

- Decision Memo for Implantable Cardioverter Defibrillators CAG-00157R4  
Dated 2/15/2018



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## NCD 20.34 Percutaneous Left Atrial Appendage Closure (LAAC)

NCD Issued May 6, 2016  
Effective February 8, 2016

The Centers for Medicare & Medicaid Services (CMS) covers percutaneous LAAC for non-valvular atrial fibrillation (NVAF) through Coverage with Evidence Development (CED) with the following conditions:

<...>

The patient must have:

<...>

- A **formal shared decision making interaction** with an independent non-interventional physician using an evidence-based decision tool on oral anticoagulation in patients with NVAF prior to LAAC. Additionally, the shared decision making interaction must be documented in the medical record.

<...>

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# Decision Memo for Implantable Automatic Defibrillators (CAG-00157R4) Dated February 15, 2018

Dated February 15, 2018

CMS is finalizing relatively minimal changes to the ICD NCD 20.4 from the 2005 reconsideration. The Decision Memo issued on February 15, 2018 includes the following changes to the NCD:

- Patient Criteria

<...>

- **Require a patient shared decision making (SDM) interaction prior to ICD implantation for certain patients.**



## AND OTHERS!

## NO INPATIENT ADMISSION ORDER NEEDED???

**2019 IPPS Proposed Rule published in the Federal Register May 7, 2018 (preamble):**

"... it has come to our attention that some otherwise medically necessary inpatient admissions are being denied payment due to technical discrepancies with the documentation of inpatient admission orders. Common technical discrepancies consist of missing practitioner admission signatures, missing co-signatures or authentication signatures, and signatures occurring after discharge."

"...we have concluded that if the hospital is operating in accordance with the hospital CoPs, medical reviews should primarily focus on whether the inpatient was medically reasonable and necessary rather than occasional inadvertent signature documentation issues unrelated to the medical necessity of the inpatient stay."

## NO INPATIENT ADMISSION ORDER NEEDED???

### 2019 IPPS Final Rule published in the Federal Register August 17, 2018

- Removing requirement that written inpatient admission orders are a specific requirement for Part A payment
- Other available documentation, i.e. physician certification statement when required, progress notes, or the medical record as a whole can support that all coverage criteria (including medical necessity) are met if the hospital is operating in accordance with CoPs
- No change in the requirement that the patient must be formally admitted as an inpatient under an order for inpatient admission, just no denial of payment for technical discrepancies for signature and/or signature timing issues if supported by physician admission and progress notes and other documentation
- CMS believes that technically defective orders are rare
- This does NOT change the “two-midnight” payment policy

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## E&Ms FOR OFFICE/OUTPATIENT SETTINGS

### 2019 MPFS Proposed Rule

- Single payment rate for E&M visit levels 2-5
  - Add on payments for inherent complexity for primary care services, inherent complexity associated with certain non-procedural services, prolonged visit
  - Multiple procedure payment adjustment when furnished with procedure on same day

Level	Current Payment* (established patient)	Proposed Payment**	Level	Current Payment* (new patient)	Proposed Payment**
1	\$22	\$24	1	\$45	\$44
2	\$45		2	\$76	
3	\$74	\$93	3	\$130	\$135
4	\$109		4	\$167	
5	\$148		5	\$172	

\* Current Payment for CY 2018

\*\* Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

- Reduced documentation requirements – focus on Medical Decision Making and/or time

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## IMAGING – Appropriate Use Criteria (AUC)

Protecting Access to Medicare Act of 2014 (PAMA) - established a program requiring adherence to AUC using clinical decision support (CDS) for advanced imaging services

Components (as originally established):

- Establishment of AUC by 11/15/2015 **COMPLETE**
- Specification of CDS mechanisms for consultation with AUC by 4/1/2016 **COMPLETE**
- AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by 1/1/2017 **DELAYED**
- Annually identify outlier ordering professionals for services after 1/1/2017 **DELAYED**

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## IMAGING – Appropriate Use Criteria (AUC)

Current status (MPFS 2018 Final Rule):

- AUC consultation and reporting requirements effective for services provided on or after 1/1/2020, and reflected on claim using ordering practitioner NPI and designated modifier
- Voluntary reporting period for “early adopters” 7/1/2018 – 12/31/2019
- Educational and operations testing 1/1/2020 – 12/31/2020 where claim will be paid regardless of whether AUC consultation is correctly included on claim
- “We hope practitioners will use this time to make good faith efforts to accurately report information on the claim”

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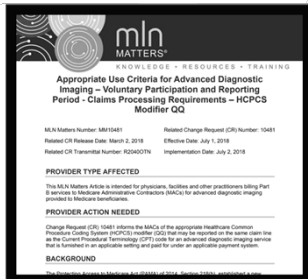
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## IMAGING – Appropriate Use Criteria (AUC)

More details are in this document



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QUESTIONS?

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