“Medicare AUC Mandate – Countdown to Launch!” Webinar Question and Answers Session Summary

Q – Will the modifier be attached to the G–code or the imaging code?

A – Modifier should be attached to the CPT code and the G–Code reported on a separate line.

Q – Will the ordering Physician be fined if they don’t provide the DS information?

A – No, there is no financial penalty for the ordering physician.

Q – How are hardships going to be reported to CMS on the claim form to distinguish on the claim if a penalty would or would not apply?

A – There are modifiers for the hardship exceptions. The modifiers may be found here: https://www.CMS.gov/Outreach–and–Education/Medicare–Learning–Network–MLN/MLNMattersArticles/Downloads/MM11268.pdf.

Q – What are the three free portal options that can be used?

A – This page is self–explanatory https://www.CMS.gov/Medicare/Quality–Initiatives–Patient–Assessment–Instruments/Appropriate–Use–Criteria–Program/CDSM.html.

Q – What type of denial code should we expect from Medicare when the order did not meet the AUC?

A – No denials will occur in 2020. CMS has not indicated details of denial codes that will be used when the program is fully implemented.

Q – Do we know if providers need to enter the information or will clinical staff be able to perform this work?

A – CMS indicated in the 2019 Medicare Physician Fee Schedule final rule that "clinical staff working on behalf of the ordering professional" may consult the CDSM.

Q – For the modifiers, such as the one for where there is no internet, is there an understanding of whether you will need further documentation in the record or maintained to support that there was no internet incapability upon audit?

A – CMS indicated they will monitor the use of exceptions, but they have not provided specific documentation guidance.

Q – We are trying to come up with a strategy for our ordering providers and making the ordering process as streamlines as possible. How are hospitals coming up with a strategy for preference lists in EPIC for commonly/most utilized procedures in ED/AMBULATORY/INPATIENT areas?

A – Most health systems begin by looking at existing order sets containing advanced imaging first, and updating those to include a reason for exam that will ensure automatic CDS adherence. You should discuss your preference list strategy with your CDSM vendor contact, as the options here are more nuanced.

Q – Will Joint Commission be looking proof of CDS in the future?

A – The PAMA law does not require Joint Commission oversight.

Q – Have the CDSM systems found a way to expedite STAT results to ordering clinicians?

A – The CDSM is only serving the role of appropriateness guidance at ordering, so we wouldn't expect a direct relationship with speed of a radiologist's reading and resulting the imaging study.

Q – Our techs are allowed to change an order based on approved protocols. What happens to the clinical decision support log/record if the order gets changed?

A – We are awaiting specific guidance from CMS on this, but we expect that if ordering of diagnostic test rules allow the order to be changed without going back to the referring physician, then an additional AUC consultation will not be necessary.

Q – We have several ordering providers that believe the CMS transmittal 2323 delays their required start date until 1/1/2021. I am hearing the requirement still remains 1/1/2020, correct?

A – CMS states that the consultations should occur beginning 1/1/2020; however, there will be no penalties during the operations and testing period if the consultation does not take place.

Q – How are you processing G-code and modifiers on your claims?

A – RBMA is advising members that the G-code will be a separate line on the claim form, the modifier is to be attached to the actual CPT code.

Q – Provide examples of systems that have implemented and are using a system successfully, please.

A – Reference R–SCAN, Peer Reviewed Papers, UVA Aurora, etc.

Q – Can you make a few cardiology-specific comments please?

A – Certain Cardiology Exams fall within the priority clinical areas (PCA) for outlier determination.

Q – Will we be compliant with the law if we process all orders with our AUC vendor but only display feedback for AUC scores < 7? What if we display no feedback for any AUC score?

A – The law requires the following information to be reported for all advanced diagnostic imaging services performed in applicable settings and billed through applicable payment systems: 1) NPI of ordering professional, 2) what CDSM was used and 3) whether the consultation result was a) adhere, b) not adhere or c) no applicable AUC were found. G–codes were created for reporting the CDSM and modifiers for the consultation result.

Q – For CareSelect you get scores 1–9 based on what study you chose. How important are the scores?

A – The scores will be translated to "adhere" or "not adhere" results, which will be reported through use of a modifier. The ordering provider can move forward with the order regardless of the score. Professionals who are deemed "outliers" (to be defined in future rulemaking) will be subject to prior authorization in the future (2023 at the earliest).

Q – Do we add the modifier to the G–code? How do we bill the modifier when the G–code is not appropriate?

A – Modifier should be attached to the CPT code and the G–Code reported on a separate line.

Q – Will CMS still pay claims that get coded with the MH modifier in 2021? Or will those be denied?

A – That remains to be seen. We expect additional information about 2021 in next year's Medicare Physician Fee Schedule proposed rule next summer.

Q – What is the requirement to be consulting during CY 2020 if there is no penalty? What will occur if no consultation occurs?

A – Nothing will happen in 2020 if no consultation occurs. We encourage providers to at least use the "MH" modifier in 2020 if no consultation information is received in order to start putting the process into place before full implementation of the program.

Q – I am currently using NDS ACR Select. We have billing difficulties for non–symptomatic clinical indications like PE, high probability or Neck trauma (age>64). Will CMS switch from symptoms to clinical indications for payment?

A – CMS has not indicated any change from current coding schemes for payment. Selection of a clinical indication is required to access AUC per regulation. The clinical indication is different than the ICD code. Additional chart documentation, beyond the reason for exam, can assist with coding and billing. Physicians should be able to provide additional text, or select multiple applicable indications, to provide full context for radiology and billing.

Q – Hospital-based only so we will be using MH on 1/1/20 as of status right now. One facility believes they will be ready 3rd quarter – no response from other two facilities. What if they are NOT ready by 1/1/21, as we have no control?

A – CMS will provide further information about 2021 in next year's Medicare Physician Fee Schedule proposed rule, published in July.

Q – What is the national average for “no score” responses to CDS software?

A – Organizations that have invested in strong governance, change management and metrics have demonstrated a low 'no score' rate. Implementation scope, EMR, workflow design and local organization culture strongly influence no score rate.

Q – Are there general education materials to show ordering providers the most common errors made when ordering studies in the priority areas?

A – www.rscan.org

Q – Is CareSelect an ACR Appropriate Use Criteria (AUC)?

A– Yes: Care Select™ Imaging/ACR Select® is a qualified AUC mechanism.

Q – Right now we are using CareSelect. Is that appropriate?

A – Yes, Care Select™ Imaging/ACR Select® is a qualified mechanism.

Q – What do you do if you receive a score of zero?

A – If the ordering professional still feels the study is the right one for that particular patient, you can still move forward. The PAMA AUC program is not prior authorization so there is no "hard stop." Those that consistently order against the AUC will be deemed "outliers" and subject to prior authorization. CMS has yet to define "outlier" and will address this in future rulemaking (2023 at the earliest).

Q – When did CMS tell you their system will not be ready in 2021? When do they think it will be ready?

A – Very recently. They did not give an indication as to when it will be ready or when this information would be publically announced.

Q – CareSelect does NOT use signs and symptoms so that gaining the clinical information needed for best interpretation and for billing are lacking. Why not match the ICD 10?

A – Clinical indications are defined separately from ICD–10, by the qPLEs (such as the ACR) to provide a level of granularity that allows a determination of appropriateness. A majority of the indications do include signs and symptoms. However, in cases where an indication does not, the physician may select multiple indications or add supplementary text to meet the needs of billing.

Q – Who is responsible to provide feedback on use of AUC to the ref docs? CMS? The FP?

A – We expect more information on the outlier calculation and process in next year's rulemaking cycle. In the meantime, radiologists should always provide feedback on the appropriateness of a selected exam.

Q – From a health system and Radiology entity standpoint working with independent providers, how do you recommend effectively requiring the AUC process prior to 2021? Especially since no penalty. Providers will naturally state, since there is no penalty I will be prepared for 2021.

A – The earlier providers begin AUC consultations, the more time you will have to work out any kinks in the system to avoid unnecessary payment denials in 2021.

Q – Does this mean that the CDM is not required to be used for any Emergency Room patients?

A – No, only those patients meeting the EMTALA definition of "emergency medical condition" (included in the answer to a question below) are exempt.

Q – Even though critical access hospital are exempt couldn't the providers there still do AUC so the radiologist will still get the necessary info for their professional fee?

A – The AUC information will not be required for PC claims of services performed in the CAH setting. CMS has stated this verbally and informally in writing, but we are waiting for guidance on how these PC claims will be identified.

Q – I understand that but those exams done at CAH are being read by radiologist that are not hospital based so CAH dos not apply to them they will need the AUC info to bill won't they?

A – The applicability of the law is based on where the TC is performed, in this case the CAH. The AUC consultation is not needed for the PC claim when the service is performed in a CAH.

Q – On 1/2020 must the codes appear on the charge sheet?

A – 2020 is an "Education and Operations Testing Period." There will be no penalties if no consultation information is provided on the claim.

Q – Therefore, if the billing department is not ready to drop the codes electronically, until 1/2021 Radiology does not need to manually add the codes. Correct?

A – Correct.

Q – When radiologists submit bills to Medicare in 2020, will we document "CDSM has been consulted" by using modifiers or by using G–codes and must a transaction number be sent to the Medicare carrier?

A – Both the G–codes (to identify the mechanism used) and modifiers (to indicate the result of the consultation) will be used. No transaction number.

Q – What modifier should be used if the professional component is read by a facility that is not exempt, but the technical component was completed at another facility that is exempt such as a CAH?

A – CMS did not yet create a modifier for this. They are aware of this issue.

Q – Should we expect to receive a paper printout with AUC consultation from Ordering Providers for every Medicare patient? Will we be able to verify consultation on a specific CDSM?

A – Eventually, as program comes on line, that will be the case for paper orders. You are able to validate CDSM data using CareSelect.

Q – We are and independent, private radiology practice with no hospital affiliation. Will ordering provider practices that have hospital affiliation still need to consult a CDSM before ordering a study that they intend to have done at a hospital imaging facility?

A – If the imaging is performed in the hospital outpatient setting and billed under the Hospital Outpatient Prospective Payment System, the CDSM consultation is required. Only hospital inpatients are exempt.

Q – If the Ordering Provider and Imaging facility are both hospital-affiliated and share the same EMR and integrated CDSM, will they have an unfair advantage over an independent practice? Since I assume the Furnishing Provider could look up the AUC results in the EMR, thus reducing the work of the Ordering Provider.

A – AUC consultation results are globally available within the NDSC tool. Making the consultation results universally available. In all cases, the referring provider has the obligation to consult the AUC. We anticipate most EMRs, if integrated with a qCDSM, will automatically add the AUC adherence information to their printed order requisitions.

Q – Is Medicare educating their patients about this process? As it may delay their care and ability to schedule their exams in a timely manner.

A – As the AUC consultation takes place electronically via a CDSM at the time of order with an instant result, this program will not delay patient care. Unlike prior authorization, the PAMA AUC program does not include a "hard stop" that may require appeals and time on the telephone. Rather, the AUC program is an educational tool for referring professionals. If the result of the AUC consultation is “not adhere”, the referring physician may still order the test if they fit it is appropriate for that particular patient.

Q – So, the AUC runs completely separately from the Medical Necessity Medicare check and they do not cancel or react to each other’s selection?

A – Correct. The AUC program is separate from local and national coverage determinations. An "adhere" result does not guarantee coverage.

Q – Why was CMS silent in the proposed rule about CAH?

A – The AUC program in general was not included in the 2020 Medicare Physician Fee Schedule proposed rule. CAHs have never been listed as an "applicable setting." CMS staff is aware of the professional component issue and will address this in future communications.

Q – How should reading radiologist handle CAH when their claims are at risk and no official communication around a CAH modifier has been provided?

A – CMS will provide instructions on this prior to program being fully implemented with payments at risk.

Q – Often, the type of insurance is not known at the time of the order, esp. in the ER. Will that issue be addressed?

A – Since 2020 is an operational and testing year, we can use that time to change processes so that this information is known at the time the exam is ordered.

Q – Does that mean all non–patient facing radiologist are not in an applicable service and not need to report?

A – No. An AUC consultation must occur for advanced diagnostic imaging services that are performed in a physician’s office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, an independent diagnostic testing facility (IDTF) or any other provider–led outpatient setting CMS determines appropriate. The requirement is for both the professional and technical components.

Q – Will you also make the information in the chat available?

A – Yes, we will post a Q&A document in the coming days.

Q – Will you provide a link to the free CDS portals?
A – Here is a list of the qualified mechanisms: https://www.CMS.gov/Medicare/Quality–Initiatives–Patient–Assessment–Instruments/Appropriate–Use–Criteria–Program/CDSM.html. Those that have a free option are noted with a *.

Q – Does EPIC discern if the patient is a CMS patient? Do AUC providers who are integrated in EPIC require the clinician to do the AUC consultation for all patient requests, or can it figure out that private paying patients do not require it?

A – Certain EHR implementations are 'payer aware,' enabling CDS to only fire for Medicare Patients. However, most organizations are choosing to enable CDS regardless of payor to improve overall imaging appropriateness.

Q – Does the payment denial due to referring not utilizing a CDS apply to both the PC and the TC component of the advanced imaging service?

A – Yes, once the program is fully operational, both the PC and TC payments are at risk. Payment is not at risk in 2020.

Q – Should hospital-based radiologists expect their PHOs and/or hospital administration to help educate the referring physicians and help with the referring physicians with their EHRs?

A –Hospitals, PHOs and radiology groups should work together to educate the referring physicians about AUC. Hospitals will be subject to financial penalties as well if AUC is not consulted.

Q – What CDS system are they using in the Michigan practice?

Care Select™ Imaging/ACR Select®

Q – We have CareSelect turned on (hospital based) and have included all high–end order types, all insurances. When we meet with referring providers, should we just ask them to provide AUC info for Medicare patients only or all patient orders?

A – PAMA only applies to Medicare patients.

Q – Are observation patients included in this process?

A – Observation patients that are not considered having an "emergent service" will be included in this process.

Q – Where can we find emergency/EMTALA conditions that would be exempt?

A – CMS will not publish a list of specific conditions that will be exempt. The CY 2018 MPFS final rule stated, "To meet the exception for an emergency medical condition, the clinician only needs to determine that the medical condition manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence

of immediate medical attention could reasonably be expected to result in: placing the health of the individual (or a woman's unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part."

Q – How is CMS educating physicians about this mandate?

A – Here is a link to CMS educational materials: https://www.CMS.gov/Medicare/Quality–Initiatives–Patient–Assessment–Instruments/Appropriate–Use–Criteria–Program/OandE.html.

Q – Is there a kit with standard letters for notifying the referring community?

A – Yes, you may find this on the ACR website: https://www.acr.org/Clinical–Resources/Clinical–Decision–Support. Scroll down to "Educate Referring Providers with the PAMA–AUC Toolkit."

Q – Has there been any mention that private payers turn to AUC vs. the traditional authorization process?

A – There have been some examples of private payer providing prior authorization exemptions to practices that utilize CDSMs.

Q – Who does the peer-to-peer with CDS?

A – CDS does not require peer-to-peer unless the ordering professional wishes to consult with the radiologist on the appropriate study to order.

Q – So, if you are seeing the elimination of need for obtaining preauthorization with CDSM consultation how does this then interact with the ABN requirement obtain this patient population?

A – As stated previously, the PAMA AUC program is separate from Medicare local and national coverage determinations, so ABN requirements do not change.

Q – Would it be reasonable to conclude that if appropriateness criteria is satisfied then this should eliminate the need (with minor exception) for obtaining a more appropriate dx code to satisfy medical necessity and therefore NOT need to capture ABNs for patient exams that have undergone AUC consultation?

A – As stated previously, the PAMA AUC program is separate from Medicare local and national coverage determinations, so ABN requirements do not change.