Oncology Coding Update for 2019

ACCC Reimbursement Meeting
Cincinnati Ohio
November 14, 2019

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- 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.
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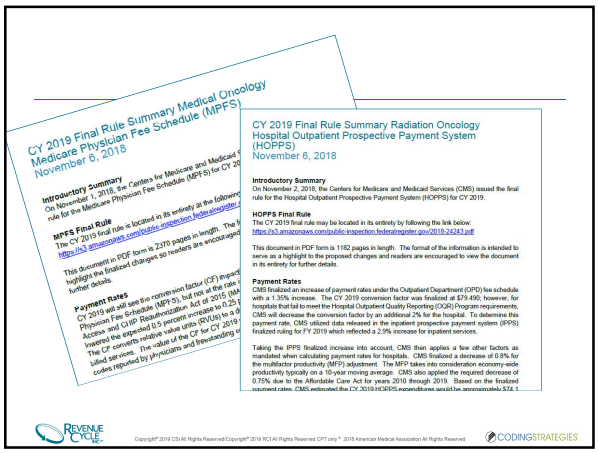

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Federal Register

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

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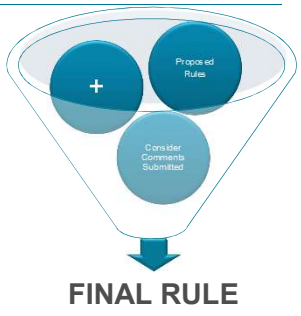
Proposed vs. Final Rule

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



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Clinical Decision Support

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Appropriate Use Criteria

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

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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.

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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

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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

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Approved Support Mechanisms

Qualified Clinical Decision Support Mechanisms as of June 2018

AIM Specialty Health ProviderPortal®*
Applied Pathways CURION™ Platform
Cranberry Peak ezCDS
eviCore healthcare's Clinical Decision Support Mechanism
MedCurrent OrderWiseTM
Medicalis Clinical Decision Support Mechanism
National Decision Support Company CareSelect™*
National Imaging Associates RadMD
Sage Health Management Solutions Inc. RadWise®
Stanson Health's Stanson CDS
Test Appropriate CDSM*

Clinical Decision Support Mechanisms with Preliminary Qualification as of June 2018

Cerner CDS mechanism
Evinance Decision Support
Flying Aces Speed of Care Decision Support
Infinx CDSM
LogicNets' Decision Engines
New Century Health's CarePro
Reliant Medical Group CDSM

*Free Tool Available

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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

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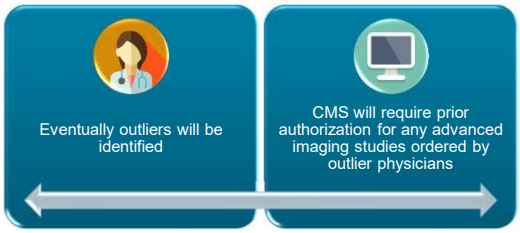
Appropriate Use Criteria



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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

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Voluntary Reporting

QQ modifier

Modifier	Description
QQ	Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional

Only indicates that AUC was consulted – not the results

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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

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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?

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New Modifiers

Table 1 HCPCS Modifiers for AUC Program

	HCPCS MODIFIER	DESCRIPTION
Emergent	MA	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
	MB	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access
Hardship	MC	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
	MD	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances
G Code Req'd	ME	The order for this service adheres to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
	MF	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
	MG	The order for this service does not have appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
	MH	Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider

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New G-Codes

Table 2 G-codes for AUC Program

G-Codes	DESCRIPTION
G1000	Clinical Decision Support Mechanism Applied Pathways, as defined by the Medicare Appropriate Use Criteria Program
G1001	Clinical Decision Support Mechanism eviCore, as defined by the Medicare Appropriate Use Criteria Program
G1002	Clinical Decision Support Mechanism MedCurrent, as defined by the Medicare Appropriate Use Criteria Program
G1003	Clinical Decision Support Mechanism Medicalis, as defined by the Medicare Appropriate Use Criteria Program
G1004	Clinical Decision Support Mechanism National Decision Support Company, as defined by the Medicare Appropriate Use Criteria Program
G1005	Clinical Decision Support Mechanism National Imaging Associates, as defined by the Medicare Appropriate Use Criteria Program
G1006	Clinical Decision Support Mechanism Test Appropriate, as defined by the Medicare Appropriate Use Criteria Program
G1007	Clinical Decision Support Mechanism AIM Specialty Health, as defined by the Medicare Appropriate Use Criteria Program
G1008	Clinical Decision Support Mechanism Cranberry Peak, as defined by the Medicare Appropriate Use Criteria Program
G1009	Clinical Decision Support Mechanism Sage Health Management Solutions, as defined by the Medicare Appropriate Use Criteria Program
G1010	Clinical Decision Support Mechanism Stanson, as defined by the Medicare Appropriate Use Criteria Program
G1011	Clinical Decision Support Mechanism, qualified tool not otherwise specified, as defined by the Medicare Appropriate Use Criteria Program

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

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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

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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

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Unknowns

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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?*

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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

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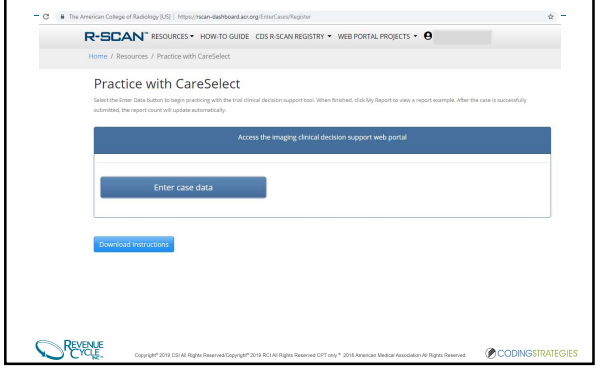

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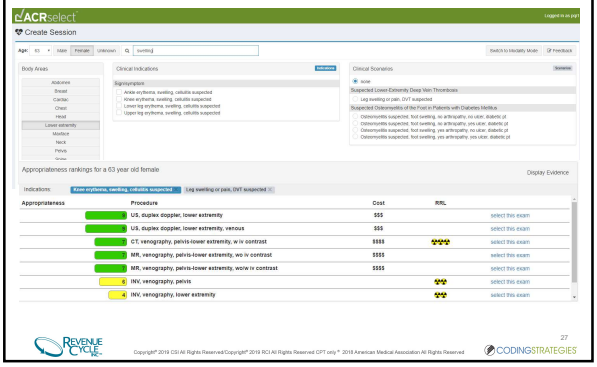
Select Body Area + Reason



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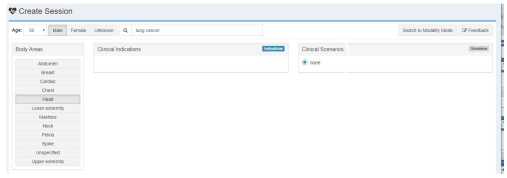
Not All Combinations Exist

- Requesting a head study for lung cancer



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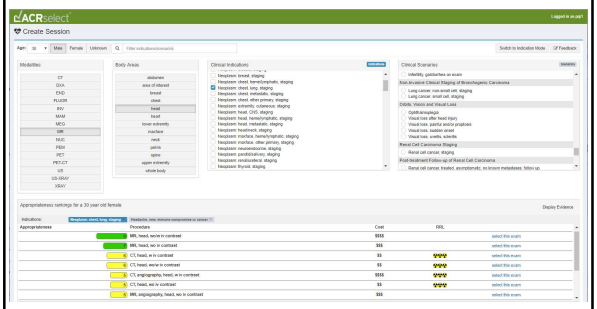
Switch to Modality Mode



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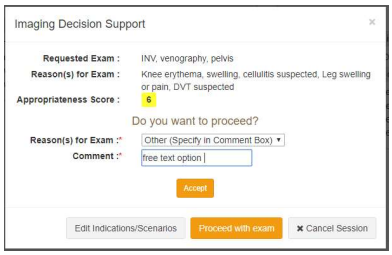
Opportunity for Free Text

- Comments are allowed – but not required



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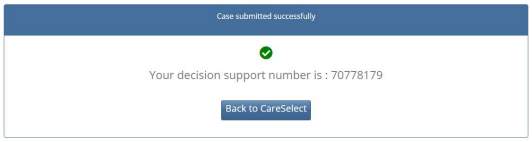
Accept To Receive CDSN

- 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



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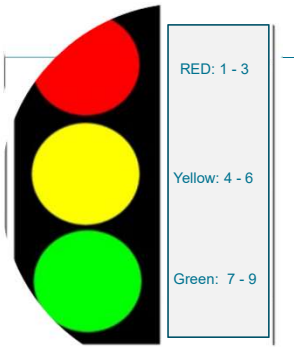
Appropriateness Criteria Score



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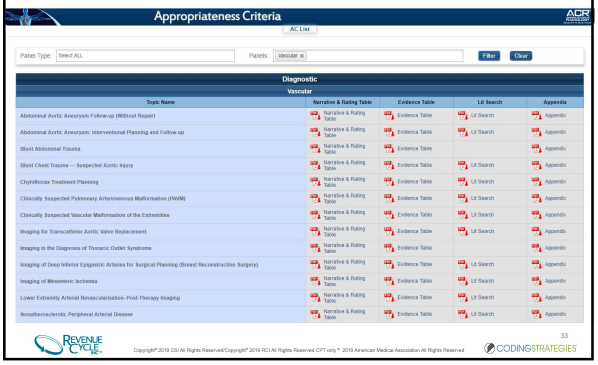
ACR – Care Select Example(s)



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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."

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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.

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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

Alcohol and drug use, abuse and dependence	Alzheimer's disease	Arthritis
Asthma	Atrial Fibrillation	Atrial flutter
Cardiomyopathy	Cerebral palsy	Congestive heart failure
Depression	Epilepsy	Intestinal obstruction
Migraines	Neoplasms	Non-pressure ulcers/ Pressure ulcers
Pneumonia	Respiratory failure	Sepsis
Strokes	Traumatic injuries	

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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**

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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

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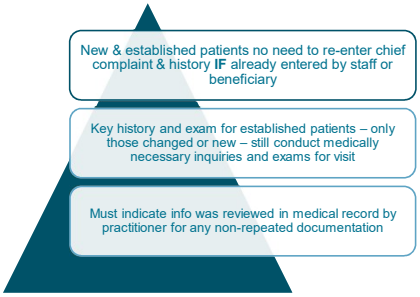
Reducing Duplication of E/M Documentation



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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

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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

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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

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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, levels 2-4 only

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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

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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;

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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:

Year	Medical Decision Making (MDM)			Time
2019	# of diagnoses or management options	Amt and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Typical time (with summary of face/face counseling/coordination of care)
2021	# and complexity of problems addressed	Amt and/or complexity of data to be reviewed and analyzed	Risk of complications and/or morbidity or mortality of patient management	Total time

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Estimated 2021 Payment Rates

TABLE 24B: Comparison of 2018 and 2021 Estimated National Payment Amounts for Visits

	Complexity Level under CPT®	Visit Code	Visit Code	Visit Code With Either Primary or specialized care add-on code*	Visit Code with New Extended Services Code
New Patient	Level 2	$76	$130	$143	$197
	Level 3	$110			
	Level 4	$167			
	Level 5	$211	$212		
Established Patient	Level 2	$45	$90	$103	$157
	Level 3	$74			
	Level 4	$109			
	Level 5	$148	$149		

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E/M Add-on Codes 2021

Code	Specialized Complexity
GCG0X	Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)
Applies to:	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
Example:	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
Code	**Prolonged Services**
GPRO1	(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)
Applies to:	Only billable with level 2-4 visit codes

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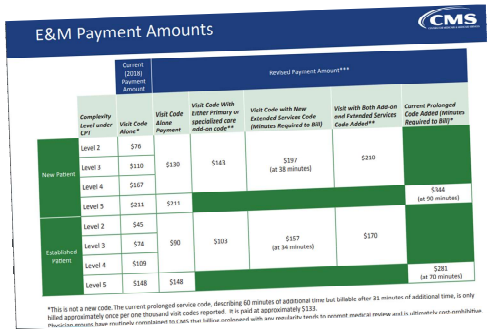
E&M Payment Amounts



	Complexity Level under CPT	Current (2019) Payment Amount: Visit Code Alone*	Revised Payment Amount***: Visit Code Alone Payment	Visit Code With either primary or specialized care add-on code**	Visit Code with New Extended Services Code (Minutes Required to Bill)	Visit with Both Add-on and Extended Services Code Added**	Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	$144 (at 90 minutes)
	Level 3	$110					
	Level 4	$167					
	Level 5	$231	$711				
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	$281 (at 70 minutes)
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.

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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

https://www.ama-assn.org/system/files/2019-03/february-2019-summary-panel-actions_0.pdf

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CAR T-cell Therapy Codes

- (CAR) T-cell therapy is cell-based gene therapy, T-cells are collected and genetically engineered to express a chimeric antigen receptor that will bind to a certain protein on a patient's cancerous cells.
- CAR T-cells are administered to the patient to attack certain cancerous cells and observed for potential serious side effects that would require medical intervention.

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CAR T-cells eff 4/1/19

CAR T-cell Therapy Codes			
HCPCS Code	Long Descriptors	SI	APC
Q2041	Axicabtagene ciloleucel, up to 200 million autologous anticd 19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9035
Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	G	9194
0537T	Chimeric antigen receptor t-cell (car-t) therapy; harvesting of blood-derived t lymphocytes for development of genetically modified autologous car-t cells, per day	B	N/A
0538T	Chimeric antigen receptor t-cell (car-t) therapy; preparation of blood-derived t lymphocytes for transportation (eg, cryopreservation, storage)	B	N/A
0539T	Chimeric antigen receptor t-cell (car-t) therapy; receipt and preparation of car-t cells for administration	B	N/A
0540T	Chimeric antigen receptor t-cell (car-t) therapy; car-t cell administration, autologous	S	5694

Effective April 1, 2019, hospitals may report CPT codes 0537T, 0538T, and 0539T, as noncovered items/services to allow for Medicare to track these services when furnished in the outpatient setting. Also, hospitals may report the CAR T-cell related revenue codes 087X (Cell/Gene Therapy) and 089X (Pharmacy) as well as new value code 86 (Invoice Cost) established by the NUBC on HOPD claims.

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11216.pdf

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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

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11168.pdf

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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

CR11168 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 11168, 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

CODE	DESCRIPTION
J1444	Fe pyro cit pow 0.1 mg iron
J7208	Inj. jivi 1 iu
J7677	Revefenacin inh non-com 1mcg
J9030	Bcg live intravesical 1mg
J9036	Inj., belrapzo/bendamustine
J9356	Inj. herceptin hylecta, 10mg
Q5112	Inj ontruzant 10 mg
Q5113	Inj herzuma 10 mg
Q5114	Inj ogivri 10 mg
Q5115	Inj rituximab-abbs bio 10 mg

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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

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Questions

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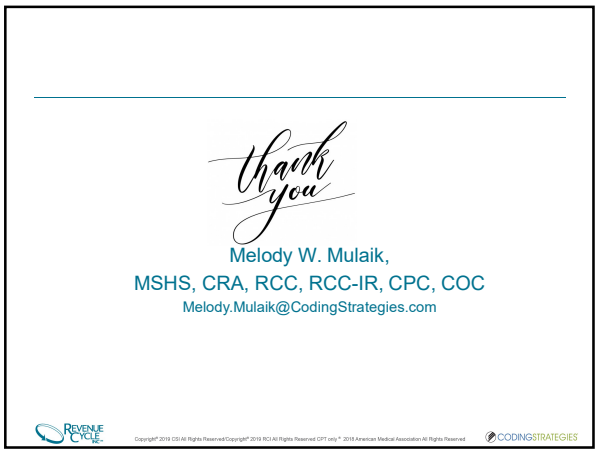
thank you
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