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TWO AUTHORIZATIONS REQUIRED BY SOME PAYERS FOR CLAIMS; USUALLY OUTPATIENT:

- This was discussed at the last MRCA March mtg & several of you worked w/me later & shared information; thank you.
- This is one of those good news/bad news stories…
- GOOD NEWS: NUBC approved that we need a way to report two authorizations, but…
- BAD NEWS: If NUBC authorizes where to put the numbers, there is no way to send the info electronically
- So, after discussion everyone agreed that this information must be able to be sent electronically. We wanted the new/future/upcoming 7030 EDI version to have the capability to list these data elements. However, the 7030 had already been finalized.
    - But GOOD NEWS, since the parties involved were all at the NUBC, they made an exception, … and are getting this it into the 7030.
- BAD NEWS: It'll be a year or two until we start using the 7030
    - History for Newbies:
    - EDI: 4010
    - About 8 years ago, the parties made upgrades & improvements to the 5010 and it was to be implemented in the 6010.
    - After finalization, the parties realized that there were many gaps with the 6010, so they decided NOT to implement it. Instead, they planned to make significant improvements to address noteworthy issues in the 7010…

Note: It takes years to make changes, this follows the DSMO process, according to regulations. At a national level, it's being discussed to eliminate or modify the DSMO process. What does this mean to you? It is significant since changes/regulation modifications could happen quicker. It also means that we (providers, payers, venders) may have challenges meeting all the changes, will enough people give pertinent feedback, will they be vetted appropriately, etc.

- Across the country, there is not a lot of input from providers.

UB04 code set: Point of Origin for Admission or Visit, FL 15 on the paper

- The NUBC has been getting questions, such as, "When pt comes from a Crisis Residential Treatment facility or a Crisis Stabilization Unit, how should we code the '*Source of Admission*?' "
- To address the various scenarios, NUBC is developing a FAQ sheet. Code it 1 or 6

PROVIDERS SEND RECORDS, BUT PAYER SAYS that they NEVER RECEIVED them:

- Provider sent records via certified mail or another method (there is proof/evidence that the payer received the records)
- An option to consider…
- **If you have the contact information for the payer/entity that said they never received the records, email them and say** *"We have a signed certified form that you received the records on Patient name: Mr. X, Acct# xxxx, Payer ID#xxxx. Since you claim to no longer have those records in your possession, please go to the following link and file a HIPAA breach report with the OCR."*
    - https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf?faces-redirect=true
- *"Please notify me when you file this report; if I do not hear from you in five working days, I will file the breach report on your behalf."*

NICU CLAIMS & OTHER ISSUES

- See me if questions; if you'd like to discuss.

ISSUES with "CAR T "BILLING – cellular therapy;

- Conflicting Instructions came out 3/15/19; transmittal 4255/CR11216;
- CMS has stated that these services are covered by CPT 0537T 0538T 0539T
- NCDs are currently being generated
- Hospitals are being told to put the charges for covered serv as Non-covered on OP claims but List them covered on IP claims. The instructions do not make sense.
- NUBC subcmte reviewing this further.

APPROPRIATE USE CRITERIA (AUC): see Med Learn Matters (MLM #10481, released 3-2-18)

- At the April National Uniform Billing Committee (NUBC) Meeting in April in Baltimore, this additional administrative burden was discussed in depth. CMS plans to release another MLM soon (probably this month) with additional information as to how hospitals should report these high-cost imaging services starting January 1, 2020.

- In a nutshell:
- To ensure that medical necessity is met when patients receive advanced diagnostic imaging, Medicare has created a program called Appropriate Use Criteria or AUC. The program affects CTs, MRIs, PET, and Nuclear Medicine tests and over 150 CPT/HCPCs.
- The program is part of The Protecting Access to Medicare Act (PAMA) of 2014; see Section 218(b). When a physician or other practitioner orders an advanced imaging service for a Medicare beneficiary, he/she will be required to consult a vendor to determine if the service is appropriate. There are dozens of vendors the provider can choose to use, but they must be approved by Medicare. They are called qualified Clinical Decision Support Mechanisms or CDSM. CDSMs are online portals through which practitioners can access the appropriate use criteria as they treat the patient. In other words, the CDSM will tell the provider if the service should be performed (if it meets the AUC criteria).

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- When doctors send patients to a hospital (or to an independent diagnostic testing facility) to receive the CT, MRI, PET, or Nuclear Medicine test, they must give the hospital/free-standing center the information/results from the CDSM. That information must also be listed and sent on the UB-04 or 1500 claim (if applicable).

- Affects UB-04 and 1500 claims when billing for outpatient CTs, MRIs, PET, & Nuclear Medicine services (150 CPT/HCPCS).
- Ordering Doctor will get the appropriate g-code and modifier from the CDSM (clinical decision support mechanism) and sends it to the provider who is doing the service
    - If doctor is too busy, the federal registrar clarifies that "nurse practitioner" or other staff can also access CDSM

- A number of doctors and hospitals have voluntarily been participating in the program since July, 2018. When hospitals send claims, they are listing modifier QQ on the claim which tells CMS that the ordering doctor consulted a CDSM. The program is complicated since hospitals must rely on the physician or practitioner to obtain the AUC data and send that information with the order.

- Which Payers is this applicable to?
    - This affects patients who have Medicare FFS (original Medicare).

  - It does not affect patients who have a Medicare Advantage plan (the HMOs, such as Medicare Plus Blue).
  - I have heard verbally that this regulation does not apply to CAHs; I have not checked

- Hospitals may do voluntary reporting now, but process will change 1-1-20
- Applicable settings have been expanded to include independent diagnostic testing facilities and the ED.

AUC Reporting Changes 1-1-2020

- The new regulations and changes to how we report AUC will change, effective 1-1-2020
- Look for MLM to be published May 2019 with details as to how it should be billed
- When hospital registers the patient, it still needs to check LCD & NCDs. If doesn't meet medical necessity criteria, then the hospital must follow ABN process.
- CMS said at the meeting (but this may change) that the new reporting, effective 1-1-20, includes eight new modifiers; examples: MF MG MA-suspected emergency or emergency. Another modifier indicates that there is a hardship exemption, such as a tornado, hurricane, or the physician does not have access to the internet…
  - We should add modifier to CPT code for the procedure
  - Look for the upcoming information in a new Med Learn Matters; all this is subject to change.

AUC-The Goal of the Program:

- Identify ordering doctors who are outliers, who order services that are not Medically Necessary.

AUC- MORE ISSUES:

- Ordering Doctor's NPI is usually the attending Provider.
- But there is not a way to report this on the UB. The Ordering Provider is a requirement of the program. This was discussed at the NUBC and voted on. As a workaround, use the K3 segment
  - Some of you may recall that this is the same segment we had used for the Present on Admission (PoA) indicator, prior to 5010 implementation.
  - TR3 notes, use 2420D at line level

AUC-ED Patients:

- AUC is also applicable for patients seen in the ED.
- Question raised at the NUBC: If a patient is seen in the ED, can we assume it's okay to use the new proposed MA modifier (suspected emergency). It would be difficult to consult a CDSM for ED patients.
  - We do not currently have answers.

I suggest we familiarize ourselves and our teams with AUC Acronyms & Terms:

- ACI-advancing care information
- AUC-appropriate use criteria
- CAH-critical access hospital
- CDSM-clinical decision support mechanism
- EPs-eligible professionals
- IDTF-independent diagnostic testing facilities
- PLE-provider-led entities
- MIPS-merit-based incentive payment system
- NPI-national provider identifier
- UCI-unique consultation identifier
- Outlier (physicians)-doctors who are not following the criteria