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Billing, Coding and Reimbursement News

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2020 MEDICARE FINAL RULES RELEASED:
Payment Increase for Nuclear Medicine

"Better accessibility, quality, affordability, empowerment, and innovation," continue to drive the federal government's policies for 2020, shaping the scope of the 2020 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System final rules, with a similar sentiment for the 2020 Medicare Physician Fee Schedule (PFS) final rule. Both are now available on the Federal Register's Public Inspection Desk, released on November 1, 2019. The multitude of policies will be effective January 1, 2020.

Final Conversion Factors

For 2020, the Centers for Medicare & Medicaid Services (CMS) finalized the OPPS conversion factor (CF) of $80.784, an increase from the 2019 CF of $79.740. Hospitals that fail to meet the Hospital Outpatient Quality Reporting (OQR) Program requirements will be subject to a reduced conversion factor of $79.770. This is an increase compared to $77.955 in 2019.

In the 2020 PFS final rule, CMS indicated a CF of $36.0896, which is a slight increase from the 2019 conversion factor of $36.0391. **According to the agency's estimates, nuclear medicine providers will see an increase in payments of one percent.** On the opposite side of the estimates, interventional radiologists will see a two percent decrease.

Reimbursement's Big Victory

The PFS proposed rule contained the possibility of staggering reimbursement cuts for myocardial PET services, with proposed cuts up to 80 percent. However, after considerable effort on the part of societies and commentators, the final rule brought a sigh of relief as CMS decided to maintain contractor pricing for 2020 instead of moving forward with the proposed cuts.

Additionally, unprecedented payment cuts of up to 157% for some SPECT and SPECT-CT studies were proposed, however, CMS also decided against those in the final rule and instead there will be a 3.5% increase in reimbursement.

Pass-Through Payment

On December 31, 2019, pass-through status for the two radiopharmaceuticals listed in Table 1 will expire. The 2020 status indicator (SI) for these codes will be "N", which means that payment will be packaged into other services and no separate ambulatory payment classification (APC) reimbursement will be received.

Table 1: Pass-Through Status Expiring

2019 HCPCS Level II Code	Code Descriptors
A9587	Gallium ga-68, dotatate, diagonistic, 0.1 millicurie
A9588	Fluciclovine f-18, diagnostic, `1 millicurie

The radiopharmaceuticals listed in Table 2 will, however, have pass-through payment status in 2020.

Table 2: Pass-Through Status in 2020

2020 HCPCS Level II Code	Code Descriptors	APCs	APC Payment Rates
A9586	Florbetapir f18, diagnostic, per study dose, up to 10 millicuries	9084	$3,028.844
A9513	Lutetium Lu 177, dotatate, therapeutic, 1 millicurie	9067	$259.170
A9590	Iodine I-131 iobenguane, 1 millicurie	9339	$311.06

Other Payment Provisions

The payment rate for drugs and therapeutic radiopharmaceuticals will remain at ASP + 6%, which was established in 2010. Additionally, for 2020, CMS finalized an increased threshold payment for therapeutic radiopharmaceuticals of $130, noting that CMS intends to package radiopharmaceuticals priced at equal to or less than $130 into the APC payments while offering separate payment for items that meet or exceed the

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threshold amount. In other words, radiopharmaceuticals that cost less than or are equal to $130 will be packaged and paid within the APCs of the related nuclear medicine service. Separate payment will be made for those that meet or exceed the threshold amount.

Payment for the radiopharmaceutical and its processing services are made through the single ASP-based payment.

For nuclear medicine services, all five APCs will see slight increases in payment rates as illustrated in Table 3 below.

Table 3: Nuclear Medicine APCs

APC	Group Title	2019 Payment Rate	2020 Payment Rate	Percentage Change
5591	Level 1 Nuclear Medicine & Related Services	$353.49	$368.08	4.0%
5592	Level 2 Nuclear Medicine & Related Services	$455.52	$471.93	3.5%
5593	Level 3 Nuclear Medicine & Related Services	$1,229.38	$1,272.05	3.4%
5594	Level 4 Nuclear Medicine & Related Services	$1,375.54	$1,443.00	4.7%
5661	Therapeutic Nuclear Medicine	$230.89	$ $237.38	2.7%

PA Physician Supervision Requirements

CMS is making changes to their PA physician supervision requirements "to give PAs greater flexibility to practice more broadly in the current healthcare system in accordance with state law and state scope of practice." The lack of existing state rules means that the agency is now pushing a revision forward to the current supervision requirement to give clarity that "physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services." CMS notes that:

- "Such physician supervision is evidenced by documenting the PA's scope of practice and indicating the working relationship(s) the PA has with the supervising physician(s) when furnishing professional services."

Information Source: *For information about the 2020 OPPS final rule, go to https://www.govinfo.gov/content/pkg/FR-2019-11-12/pdf/2019-24138.pdf*

For more information about the 2020 MPFS final rule, go to https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf

CRITICAL 2020 NUCLEAR MEDICINE CODING UPDATES:
SPECT/CT, Myocardial PET Changes Drive Impact

Nuclear medicine will be impacted by a multitude of deletions, revisions, and new codes starting January 1st for single-photon emission computed tomography (SPECT/CT) and myocardial PET.

SPECT/CT

A variety of revisions, additions and deletions will re-shape coding and billing for SPECT and SPECT/CT services come January 1st, with most of the current, site-specific codes being deleted and replaced with a new, more generic code set where code selection is based on the type of imaging, the number of areas imaged and the number of days which that imaging is performed.

Codes 78800, 78801, 78802, 78803, and 78804 underwent significant description revisions, and four new codes were added for these services.

- 78800 Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed) planar, single area (e.g., head, neck, chest, pelvis), single day imaging
- 78801 planar, 2 or more areas (e.g., abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days
- 78802 planar, whole body, single day imaging
- 78804 planar, whole body, requiring 2 or more days imaging
- 78803 tomographic (SPECT), single area (e.g., head, neck, chest, pelvis), single day imaging
- 78830 tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/ detection of pathology, single area (e.g., head, neck, chest, pelvis), single day imaging
- 78831 tomographic (SPECT), minimum 2 areas (e.g., pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more day
- 78832 tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/ detection of pathology, minimum 2 areas (e.g., pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days
- 78835 Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure

Codes 78205, 78206, 78607, 78710 78805, 78806, 78807, 78320, and 78647 were deleted for 2020. The only site-specific SPECT codes remaining are for myocardial perfusion and parathyroid imaging. Continue to report these procedures as usual.

In addition, codes 78805-78807 were deleted and imaging for inflammatory processes was added to the 78801-78832 series.

Myocardial PET

The current myocardial PET codes (78459, 78491, and 78492) underwent significant description revisions and five additional codes have been introduced to include component services of cardiac PET. Additionally, add-on code 0482T (absolute quantification of myocardial blood flow) has been deleted and replaced with category I code 78434.

- 78459 Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study
- 78429 with concurrently acquired computed tomography transmission scan
- 78491 Myocardial imaging, positron emission tomography (PET), perfusio study (including ventricular wall motion[s] and/ or ejection fraction[s], when performed) single study, at rest or stress (exercise or pharmacologic)
- 78430 single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
- 78492 multiple studies at rest and stress (exercise or pharmacologic)

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- 78431 multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
- 78432 Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (e.g., myocardial viability)
- 78433 with concurrently acquired computed tomography transmission scan
- 78434 Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure

With the new year just around the corner, ensure all staff are aware of and understand these updates.

APPROPRIATE USE CRITERIA IS SET FOR 2020: PAMA's Penalties on the Horizon

Not only will code changes be a driving factor heading into the new year, but the appropriate use criteria (AUC) program implementation is now moving full speed ahead with new reporting guidelines, modifiers, and G-codes released by the Centers for Medicare & Medicaid Services (CMS). This regulation impacts all who provide Medicare patients with advanced imaging services. Starting January 1, 2020, physicians, other practitioners, and facilities ordering these services for Medicare beneficiaries are obligated to consult AUC through a qualified clinical decision support mechanism (CDSM). Additionally, this consulted information must be provided to professionals and facilities furnishing the advanced imaging service on the test order to be reported when billing Medicare.

AUC Regulatory Policy Reach

The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b), created a new program intended to increase the rate of appropriate ordering of advanced diagnostic imaging services for Medicare beneficiaries. The four key areas of advanced imaging services subject to this rule are:

- magnetic resonance imaging (MRI)
- nuclear medicine
- positron emission tomography (PET)
- computed tomography (CT)

CMS states the AUC policy applies to all the above advanced diagnostic imaging services performed in a "physician's office, hospital outpatient department (including the emergency department), an ambulatory surgical center or an independent diagnostic testing facility (IDTF) and whose claims are paid under the physician fee schedule, hospital outpatient prospective payment system or ambulatory surgical center payment system."

The program requires that when a practitioner orders an advanced diagnostic imaging service for a Medicare beneficiary, he/she, or clinical staff acting under his/her direction, are obligated to consult a qualified a CDSM. The assessment of AUC occurs through these CDSM electronic portals. Providers can access imaging AUC through a stand-alone CDS system or by using CDS software that is incorporated into their electronic health record system.

The CDSM will give a determination of whether a specific order complies with AUC or if the AUC was not applicable. Not applicable means that no such AUC exits to address the patient's clinical condition.

CMS has outlined that the processing systems will accept claims containing a current Procedural Terminology (CPT) or HCPCS C-code, with a line item HCPCS modifier appended to explain either the level of compliance to AUC, or an exception to the program, along with a separate line item G-code to describe the qualified CDSM consulted.

During 2020, the program will be active as an education and operations testing period. Over the course of this period, claims will not be denied if they fail to include proper AUC consultation information. **For 2021, failure to comply will carry significant consequences. Expect to receive zero payment on claims that fail to comply. This means that payment will be denied for the professional and technical components along with any charges billed globally.**

Claims for advanced diagnostic imaging services should include:

- The ordering professional's national provider identifier (NPI)
- Which CDSM was consulted among the multiple qualified CDSMs available
- Identifying if the service ordered would or would not adhere to consulted AUC or if the consulted AUC was designated as not applicable to the ordered service.

The list is subject to updates. AUC consultation is still required for all advanced diagnostic imaging services and not only those that fall under the priority clinical areas.

Hardship Exceptions

As with many rules and changes some exceptions will exist. CMS has outlined the following specific exceptions.

- Certain emergency services, if administered to patients with specific emergency medical conditions (as defined in Section 1867(e)(1) of the Act).
- Inpatients that are billed under Medicare Part A.
- Ordering professionals, who happen to undergo a significant hardship. This includes:
  - Insufficient internet access
  - Vendor issues with EHR or CDSM
  - Extreme and uncontrollable circumstances

Modifiers of Importance

Eight HCPCS modifiers were created for the scope of this program. These should be reported on the same line as the CPT code for the provided advanced diagnostic imaging service:

Table 1: HCPCS Modifiers

CDSM Not Consulted – Emergency	
MA	Ordering professional is not required to consult a CDSM due to service being rendered to a patient with a suspected or confirmed emergency medical condition
CDSM Not Consulted – Hardship	
MB	Ordering professional is not required to consult a CDSM due to the significant hardship exception of insufficient internet access
MC	Ordering professional is not required to consult a CDSM due to the significant hardship exception of electronic health record or CDSM vendor issues
MD	Ordering professional is not required to consult a CDSM due to the significant hardship exception of extreme and uncontrollable circumstances
CDSM Consulted	
ME	The order for this service adheres to the AUC in the CDSM consulted by the ordering professional
MF	The order for this service does not adhere to the AUC in the CDSM consulted by the ordering professional
MG	The order for this service does not have AUC in the CDSM consulted by the ordering professional
Unknown	
MH	Unknown if the ordering professional consulted a CDSM for this service, related information was not provided for the furnishing professional or provider

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| *Appropriate Use Criteria is Set for 2020... continued from page 3* |

It is important to note that when professionals use either HCPCS modifier ME, MF, or MG on the claim line for imaging services, an additional G-code must be reported as a separate line item. The G-code describes which qualified CDSM was consulted. Multiple G-codes on a single claim are acceptable. Note that the G-codes will not have corresponding payment rates and are for reporting purposes only.

Table 2: G-Codes

G-Code	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

The 2020 Medicare Physician Fee Schedule final rule did not contain any further discussion on the AUC program implementation. However, CMS released claims processing guidance in July 2019. The claims processing information can be found here: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf*

Other Information Sources: *https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10481.pdf*

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AUCDiagnosticImaging-909377.pdf

https://www.acr.org/-/media/ACR/NOINDEX/AC/PAMA-CDS-Flyer.pdf

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