

Federal Regulatory Update

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Overview

- Appropriate Use Criteria
- Principal Care Management
- Virtual Care
Communications Services
- Other regulatory updates
from the past year



Appropriate Use Criteria Mandate

- The Appropriate Use Criteria (AUC) Mandate is intended to improve the appropriateness of advanced imaging orders for Medicare patients
- Terms: AUC vs. CDS vs. CDSM vs. qCDSM
- Why should the RHC community care?
 - Your clinicians will need to consult with an Appropriate Use Criteria set through a qualified Clinical Decision Support Mechanism when ordering advanced imaging
 - If the clinicians do not do this, then the advanced image will not be paid by Medicare in 2021
- 2020 is an Educational and Operational Testing Period whereby advanced imaging claims will still be paid if this consultation does not occur, but CMS is encouraging all providers consult with AUC and test their systems
- The imaging facilities or hospital outpatient departments that your patients go to may begin asking you (this year) to engage in this process and give them specific information on the imaging order

Advanced Imaging Orders



- The following information must go on the advanced imaging claim in order to be paid in 2021, and can be placed on the claim to test processes in 2020:
 - Ordering Professional's NPI
 - The qCDSM used to consult a set of Appropriate Use Criteria
 - G-codes are used to report which qCDSM was used
 - The result of the consultation (i.e. did the image adhere to, not adhere to, or not apply to the AUC)
 - Results of consultation reported with modifier codes
- Different imaging facilities may want this information in different formats but they will need the information communicated to them in some way in order to get paid by Medicare in 2021.

Consulting the qCDSM

- CMS List of “qualified Clinical Decision Support Mechanisms” and their corresponding G-codes can be found here: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM>
- RHCs and their clinicians should find a qCDSM and familiarize themselves with the portal, many of the qCDSMs can be embedded into your EHR.
- There are qCDSMs that are free and available through an online portal.

| Mechanism Name | Code |
|--|-------|
| eviCore healthcare's Clinical Decision Support Mechanism | G1001 |
| MedCurrent OrderWise™ | G1002 |
| Medicalis Clinical Decision Support Mechanism | G1003 |
| National Decision Support Company CareSelect™* | G1004 |
| National Imaging Associates RadMD | G1005 |
| Test Appropriate CDSM* | G1006 |
| AIM Specialty Health ProviderPortal®* | G1007 |
| Cranberry Peak ezCDS | G1008 |
| Sage Health Management Solutions Inc. RadWise® | G1009 |
| Stanson Health's Stanson CDS | G1010 |
| AgileMD's Clinical Decision Support Mechanism | G1011 |
| EvidenceCare's Imaging Advisor | G1011 |
| InveniQA's Semantic Answers in Medicine™ | G1011 |
| Reliant Medical Group CDSM | G1011 |
| Speed of Care CDSM | G1011 |
| HealthHelp's Clinical Decision Support Mechanism | G1011 |
| INFINX CDSM | G1011 |
| LogicNets AUC Solution* | G1011 |

The Result of qCDSM Query

- When the RHC clinician consults the AUC through a qCDSM, they criteria will yield an appropriateness result.
- The modifier ME indicates that the order adheres to the AUC.
- The modifier MF indicates that the order does not adhere to the AUC
 - CMS will still pay for the imaging in this scenario
 - Eventually ordering professionals who order a lot of “non-adhering” images will be subject to prior authorization
- Exceptions & their modifiers

Appropriate Use Criteria Modifier Codes

| | |
|-----------|---|
| 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 |
| 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 |
| 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 |
| QQ | Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional (effective date: 7/1/18) |

Exceptions to AUC

- Applies only to advanced imaging performed in outpatient settings
 - Advanced imaging = MRI, CT scan, nuclear medicine including PET scan
- Does not apply to other imaging such as X-ray or ultrasound
- If the patient is an “emergency medical condition” consultation is not required (modifier MA)
- If the ordering physician has a significant hardship due to either lack of internet connectiveness (modifier MB), EHR issues (modifier MC), or extreme circumstances (modifier MD)
- *If the image is performed in a Critical Access Hospital, the program is not applicable because CAHs are not paid through an “applicable payment system”*
- Applicable payment systems include: Hospital Outpatient Prospective Payment System, Physician Fee Schedule, Ambulatory Surgical Center Payment System
- RHCs are not paid through an applicable system but the applicability of the AUC mandate hinges on the payment system for the location where the patient receives the advanced imaging

Delegation of qCDSM consult

- The ordering professional must consult the AUC through a qCDSM themselves or have clinical staff under the direction of the ordering professional consult the AUC on their behalf.

The individual performing the consultation must have “sufficient clinical knowledge to interact with the CDSM and communicate with the ordering professional.”



Principal Care Management

- RHCs cannot bill for Principal Care Management Services in 2020
- There was confusion in the initial final rule posted about whether or not RHC could bill for Principal Care Management Services with the Chronic Care Management code G0511.
- CMS clarified that PCM services are not billable through G0511 in 2020
- PCM is very similar to chronic care management with the notable exception that the patient only has one chronic condition.
- NARHC is working with CMS to see if we can expand the benefit to RHCs in 2021

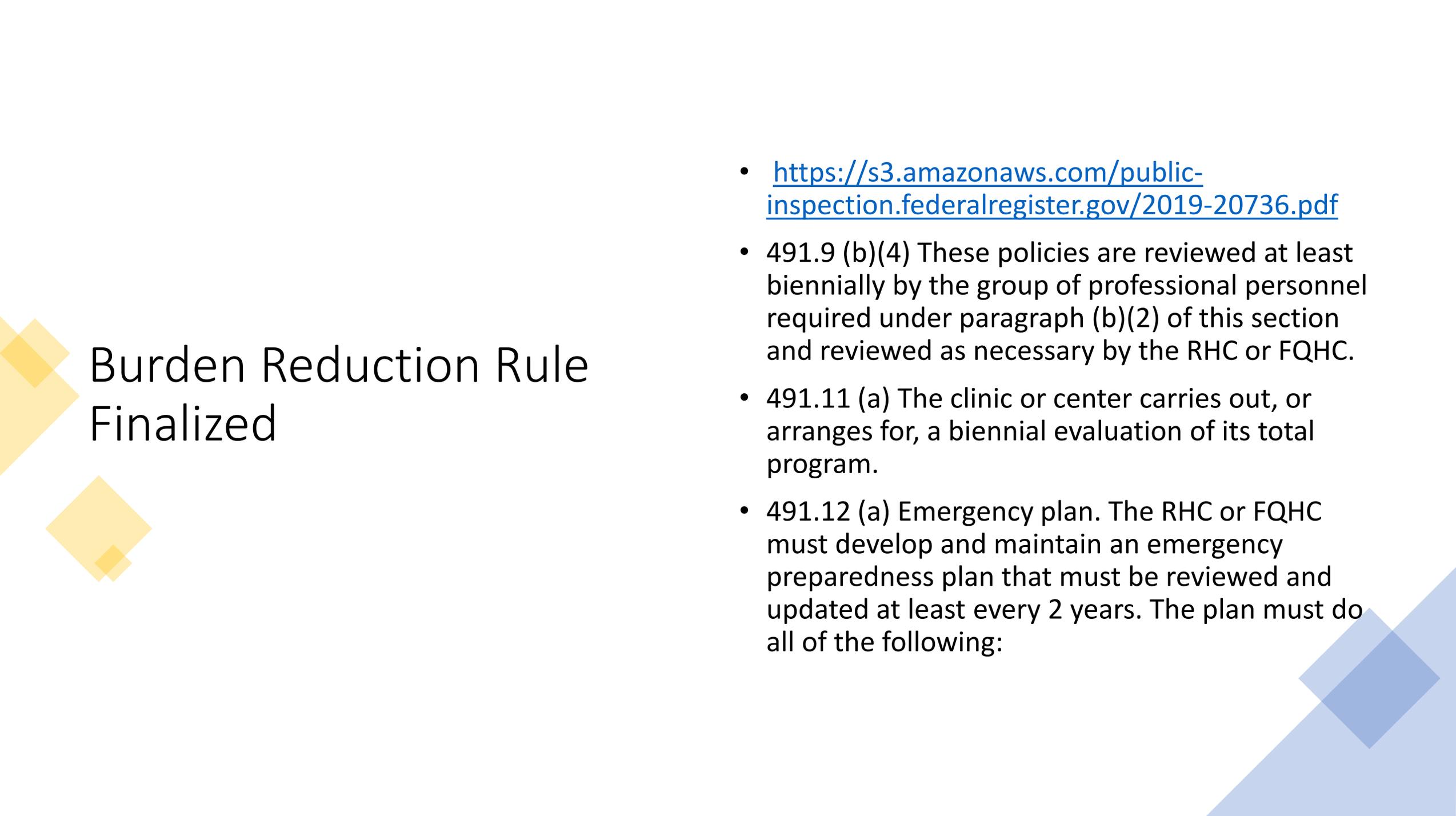
Virtual Care Communications

- RHCs receive payment for communication technology-based services or remote evaluation services when an RHC practitioner provides at least 5 minutes of communications-based technology or remote evaluation services to a patient who has been seen in the RHC within the previous year.
- RHCs may only bill for these services when the medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and does not lead to an RHC service within the next 24 hours or at the soonest available appointment, since in those situations, Medicare already pays for the services as part of the RHC per-visit payment.
- G0071
- Relevant FAQ: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf>

Regulatory Relief Final Rule



- Changes the annual review of patient care policies and program evaluations to an every-other-year requirement.
- Allows facilities to review their Emergency Preparedness program every other year instead of every year.
- Eliminates the requirement that RHCs must document their communication with emergency preparedness officials.
- Allows facilities to train their staff on emergency preparedness every other year.
- Reduces the number of emergency preparedness exercises required per year to one.



Burden Reduction Rule Finalized

- <https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-20736.pdf>
- 491.9 (b)(4) These policies are reviewed at least biennially by the group of professional personnel required under paragraph (b)(2) of this section and reviewed as necessary by the RHC or FQHC.
- 491.11 (a) The clinic or center carries out, or arranges for, a biennial evaluation of its total program.
- 491.12 (a) Emergency plan. The RHC or FQHC must develop and maintain an emergency preparedness plan that must be reviewed and updated at least every 2 years. The plan must do all of the following:

- (2) Testing. The RHC or FQHC must conduct exercises to test the emergency plan at least annually. The RHC or FQHC must do the following:
 - (i) Participate in a full-scale exercise that is community-based every 2 years; or
 - (A) When a community-based exercise is not accessible, an individual, facility-based functional exercise every 2 years; or.
 - (B) If the RHC or FQHC experiences an actual natural or man-made emergency that requires activation of the emergency plan, the RHC or FQHC is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
 - (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to following:
 - (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
 - (B) A mock disaster drill; or
 - (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
 - (iii) Analyze the RHC or FQHC's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the RHC or FQHC's emergency plan, as needed.

Appendix G Revision (Allows RHCs to determine Drugs and Biologics necessary for emergencies)

- Previously, RHCs were required to stock drugs and biologics from each of the following categories: 1-Analgesics; 2-Local Anesthetics; 3-Antibiotics; 4-Anticonvulsants; and 5-Antidotes, emetics, serums & toxoids. However, as of September 3rd, 2019, RHCs will only be required to consider each category when they craft their written policies. This means that RHCs will not be required to stock snake antidote, emetics, or anticonvulsants! Here is the key line from the new policy:
- *While each category of drugs and biologics must be considered, all are not required to be stored...*
- We will still be required to store drugs and biologics for emergencies, but now, CMS is allowing us to determine which drugs and biologics are most appropriate for our communities:
- *...when determining which drugs and biologics it has available for purposes of addressing common life-threatening injuries and acute illnesses, the RHC should consider, among other things, the community history, the medical history of its patients and accepted standards of practice. The clinic should have written policies and procedures for determining what drug/biologics are stored and that address the process for determining which drugs/biologics to store, including identifying who is responsible for making this determination.*
- <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-19-18-RHC.pdf>



Trump Administration Proposal on Non-Discrimination Rules

- The Department proposes to repeal *in toto* the Section 1557 provisions on taglines the use of language access plans, and notices of non-discrimination. The Department also proposes to replace the requirements for remote English-language video interpreting services with comparably effective requirements with respect to audio-based services. The current rule's provisions were not justified by need, were overly burdensome compared to the benefit provided, and created inconsistent requirements for HHS funded health programs or activities as compared to HHS funded human services programs or activities. The Department proposes to return to the language access standard previously in place under the existing Title VI regulation as interpreted by the U.S. Supreme Court and HHS and the Department of Justice in their LEP guidance documents.
- For reasons explained more fully below, the 2016 estimate of \$7.2 million in onetime costs stemming from the notice and taglines requirement was a gross underestimation, and thus this proposed rule's elimination of those requirements would generate a large economic savings of approximately \$3.6 billion over five years based on the proposed repeal of the notice and taglines provision.
- <https://www.hhs.gov/sites/default/files/1557-nprm-hhs.pdf>

Trump Administration Request for Information

- The Trump Administration recently requested stakeholders submit proposals for changes to regulations that unnecessarily restrict or limit the ability of Physician Assistants and Nurse Practitioners to work to the top of their licenses. In effect, are there federal regulations that unnecessarily restrict or limit PAs or NPs to practice in a manner consistent with what they are permitted to do under state law or state regulatory mechanism.
- NARHC submitted comments on this Request For Information
- Potential for additional rulemaking on this topic in the coming year

Updates to Important RHC Documents

- State Operations Manual Appendix G ~ Updated 1/26/18
- <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/FQHC-RHC-FAQs.pdf>
- Update to Medicare Benefit Policy Manual Chapter 13 ~ Updated 12/20/19
- <https://www.cms.gov/media/125181>



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