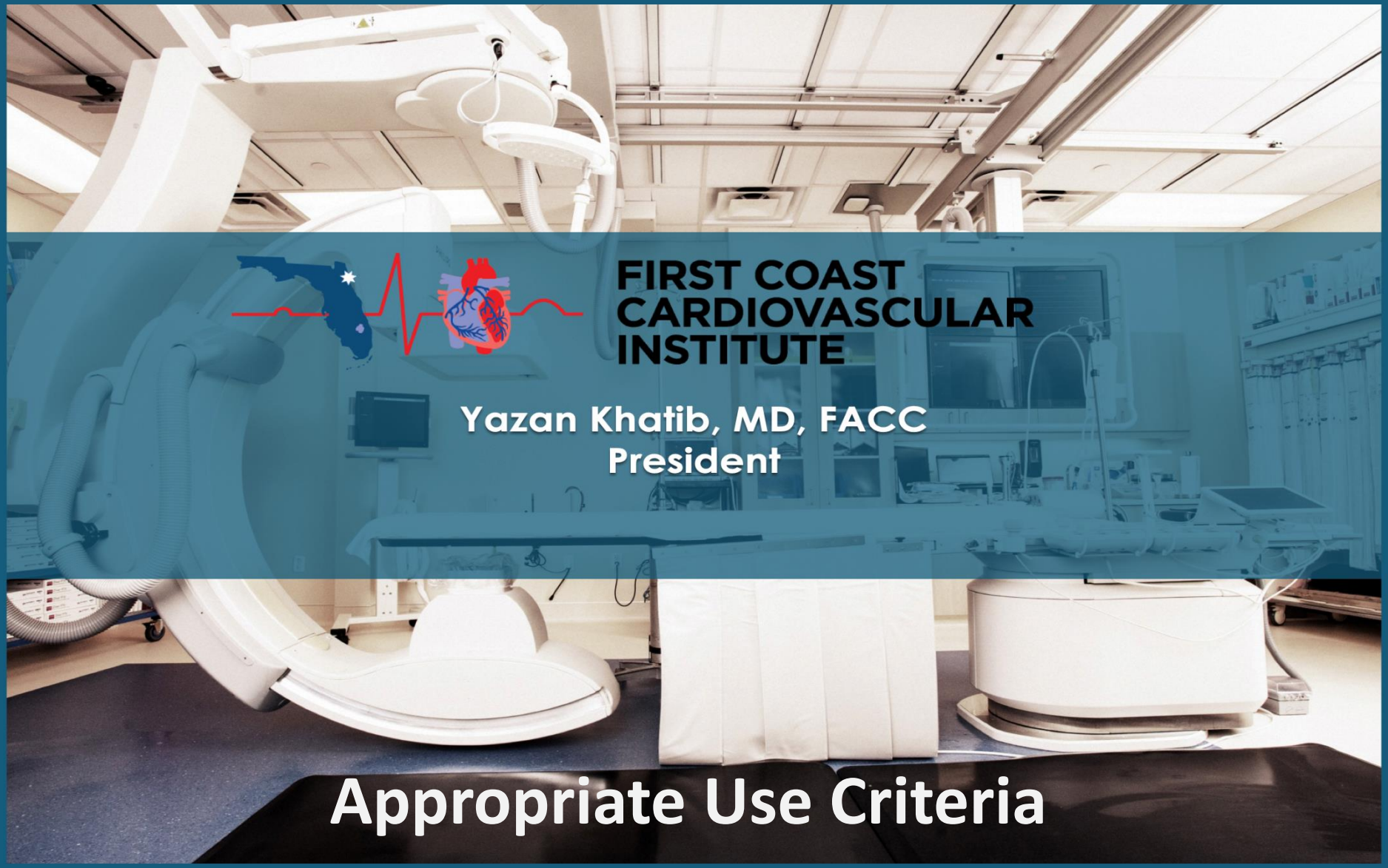

FIRST COAST CARDIOVASCULAR INSTITUTE

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Appropriate Use Criteria

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OEIS OUTPATIENT ENDOVASCULAR AND INTERVENTIONAL SOCIETY

OEIS 6TH ANNUAL NATIONAL SCIENTIFIC MEETING
April 4-6, 2019
St. Petersburg, Florida

Appropriate Use Criteria
Per CMS

Per the Societies

To be differentiated from Medical Necessity criteria
IN LCD's and of different commercial payors

AUC Per CMS Scope

The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b), to govern advanced diagnostic imaging services

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

AUC Per CMS
How it works

- At the time a practitioner orders a service
- He/she will be required to consult a qualified Clinical Decision Support Mechanism (CDSM).
- CDSMs are electronic portals through which appropriate use criteria (AUC) is accessed.
- The CDSM provides a determination of whether the order adheres to AUC, or if the AUC consulted was not applicable

AUC Per CMS
Program Timeline

- **Beginning July 1, 2018** the program is operating under a voluntary participation
- Prior to this date the program will operate in an Education and Operations Testing Period starting **January 1, 2020**
- Set to be fully implemented on **January 1, 2021,** Claims that fail to append this information will not be paid.

AUC Per CMS

Disease states of interest

Priority Clinical Areas as of November 2016

Coronary artery disease (suspected or diagnosed)

Suspected pulmonary embolism

Headache (traumatic and nontraumatic)

Hip pain

Low back pain

Shoulder pain (to include suspected rotator cuff injury)

Cancer of the lung (primary or metastatic, suspected or diagnosed)

Cervical or neck pain

Provider Led Entities PLE
Background

- National professional medical specialty society or other organization
- Comprised primarily of providers
- Predominantly provide direct patient care.
- Once a PLE is qualified, the appropriate use criteria (AUC) developed, modified or endorsed by the entity are considered specified applicable AUC.

2018 Qualified Provider Led Entities PLE's

- American College of Cardiology Foundation
- American College of Radiology
- Banner University Medical Group-Tucson University of Arizona
- CDI Quality Institute
- Cedars-Sinai Health System
- High Value Practice Academic Alliance*
- Intermountain Healthcare
- Massachusetts General Hospital, Department of Radiology
- Medical Guidelines Institute

2018 Qualified Provider Led Entities PLE's

Memorial Sloan Kettering Cancer Center
National Comprehensive Cancer Network
Sage Evidence-based Medicine & Practice Institute
Society for Nuclear Medicine and Molecular Imaging
University of California Medical Campuses
University of Pennsylvania Health System*
University of Texas MD Anderson Cancer Center*
University of Utah Health
University of Washington School of Medicine
Virginia Mason Medical Center
Weill Cornell Medicine Physicians Organization

Peripheral Artery Intervention Writing Group, Bailey SR, Bechman JA,e t al.

ACC/AHA/SCAI/SIR/SVM 2018 appropriate use criteria for peripheral artery intervention:

a report of the American College of Cardiology appropriate use criteria task force, American Heart Association, Society for Cardiovascular Angiography and Interventions, Society of Interventional Radiology, and Society for Vascular Medicine. *J Am Coll Cardiol*2018

The rating panel scored each indication using the following definitions and their associated numeric ranges:

Median Score 7 to 9: **Appropriate care** for specific indication (treatment **is** generally acceptable and **is** a reasonable approach for the indication).

An appropriate option for management of patients in this population due to benefits generally outweighing risks; effective option for individual care plans although not always necessary depending on physician judgment and patient-specific preferences (i.e., treatment is generally acceptable and is generally reasonable for the indication).

Median Score 4 to 6: **May Be Appropriate care** for specific indication (treatment **may** be generally acceptable and **may**be a reasonable approach for the indication). May Be Appropriate also implies that more research and/or patient information is needed to classify the indication definitively.

At times an appropriate option for management of patients in this population due to variable evidence or lack of agreement regarding the benefits/risks ratio, potential benefit based on practice experience in the absence of evidence, and/or variability in the population; effectiveness for individual care must be determined by a patient's physician in consultation with the patient based on additional clinical variables and judgment along with patient preferences (i.e., treatment may be acceptable and may be reasonable for the indication).

Median Score 1 to 3: **Rarely Appropriate care** for specific indication (treatment **is not** generally acceptable and **is not** a reasonable approach for the indication).

Rarely an appropriate option for management of patients in this population due to the lack of a clear benefit/risk advantage; rarely an effective option for individual care plans; exceptions should have documentation of the clinical reasons for proceeding with this care option (i.e., treatment is not generally acceptable and is not generally reasonable for the indication)

TABLE 3.1 Critical Limb Ischemia

Indications	AUC Score: Continue or Intensify Medical Therapy	AUC Score: Endovascular Treatment	AUC Score: Surgical Treatment
21. ■ Aortoiliac		A (8.5)	A (8)
22. ■ SFA and popliteal artery		A (8)	A (8)
23. ■ Below the knee		A (8)	A (8)

A = Appropriate; AUC = Appropriate Use Criteria; SFA = superficial femoral artery.

TABLE 5.4 SFA and Popliteal Artery

Indications	AUC Score: Atherectomy	Balloon Angioplasty	Drug-Coated Balloon	Bare Metal Stent	Drug-Eluting Stent	Covered Stent
32. ■ Length <100 mm	M (6)	A (7)	A (7)	A (7)	A (7)	M (6)
33. ■ Length ≥100 mm	M (5)	M (5)	A (7)	A (7)	A (7)	M (6)

A = Appropriate; AUC = Appropriate Use Criteria; M = May Be Appropriate; SFA = superficial femoral artery.

TABLE 5.5 Below the Knee

Indications	AUC Score: Atherectomy	Balloon Angioplasty	Drug-Coated Balloon	Bare Metal Stent	Drug-Eluting Stent	Covered Stent
34. ■ Length <100 mm	M (4)	A (7)	M (4)	M (5)	A (7)	R (3)
35. ■ Length ≥100 mm	M (4)	A (7)	M (4)	M (5)	M (6)	R (3)

A = Appropriate; AUC = Appropriate Use Criteria; M = May Be Appropriate; R = Rarely Appropriate

TABLE 6.1 In-Stent Restenosis

Indications	AUC Score: Continue or Intensify Medical Therapy	Endovascular Treatment	Surgical Treatment
Recurrent Symptoms			
36. ■ Focal stenosis	A (9)	A (7)	M (5)
37. ■ Diffuse stenosis	A (9)	A (7)	M (6)
Asymptomatic			
38. ■ Focal stenosis	A (9)	M (5)	R (2)
39. ■ Diffuse stenosis	A (9)	M (4)	R (3)

A = Appropriate; AUC = Appropriate Use Criteria; M = May Be Appropriate; R = Rarely Appropriate.

TABLE 6.2 Venous Bypass Graft Failure

Indications	AUC Score: Endovascular Treatment — Balloon Angioplasty, Stenting, and/or Catheter-Directed Thrombolysis	AUC Score: Surgical Treatment — Vein Patch Angioplasty or Interposition Graft
Stenotic Lesions Developing After 30 days		
40. ■ Focal stenosis	A (7)	M (5)
41. ■ Diffuse stenosis	M (6)	M (6)
42. ■ Thrombosed graft	M (6)	M (6)

A — Appropriate; AUC — Appropriate Use Criteria; M — May Be Appropriate

TABLE 5.3 Diffuse Common Iliac Artery and External Iliac Artery

Indications	AUC Score: Atherectomy	AUC Score: Balloon Angioplasty	AUC Score: Stent
30. ■ Unilateral EIA stenosis with multiple CIA stenoses	R (2)	M (5)	A (8)
31. ■ Chronic total occlusion	R (2)	M (4)	A (8)

A = Appropriate; AUC = Appropriate Use Criteria; CIA = common iliac artery; EIA = external iliac artery; M = May Be Appropriate; R = Rarely Appropriate.

TABLE 1.4 Incidentally Discovered RAS

Indications	AUC Score: Continue or Intensify Medical Therapy	AUC Score: Renal Stent Placement (Primary Stenting) – Atherosclerotic Lesions
Hemodynamically Significant RAS (With a Severe [70%–99%] RAS or 50%–69% RAS With Hemodynamic Significance)		
11. ■ Unilateral RAS	A (9)	R (2)
12. ■ Bilateral RAS or a solitary viable* kidney with RAS	A (9)	R (2)

*Viable is pole-to-pole kidney length ≥7 cm.

A = Appropriate; AUC = Appropriate Use Criteria; R = Rarely Appropriate; RAS = renal artery stenosis.

TABLE 1.5 Borderline (50%–69%) RAS Without Hemodynamic Confirmation of Severity

Indications	AUC Score: Continue or Intensify Medical Therapy	AUC Score: Renal Stent Placement (Primary Stenting) – Atherosclerotic Lesions
13. ■ Unilateral RAS, bilateral RAS, or a solitary viable* kidney with RAS	A (9)	R (2)

*Viable is pole to pole kidney length of ≥ 7 cm.

A = Appropriate; AUC = Appropriate Use Criteria; R = Rarely Appropriate; RAS = renal artery stenosis.

TABLE 1.3 Cardiac Destabilization

Indications	AUC Score: Continue or Intensify Medical Therapy	AUC Score: Renal Stent Placement (Primary Stenting) — Atherosclerotic Lesions
Hemodynamically Significant RAS (With a Severe [70%–99%] RAS or 50%–69% RAS With Hemodynamic Significance)		
8. ■ Recurrent heart failure ■ Uncontrolled on maximal medical therapy		M (6)
9. ■ Sudden-onset flash pulmonary edema		A (7)
10. ■ Uncontrolled unstable angina despite maximal medical therapy		M (6)

A = Appropriate; AUC = Appropriate Use Criteria; M = May Be Appropriate; RAS = renal artery stenosis.

Not to be confused with **Medical Necessity**

- Criteria set by LCD's and commercial payors
- Usually inspired by societal AUC
- Usually more strict than Societal AUC's

AUC will not dictate medical necessity for payment.

Medical Necessity

- For every service billed by your practice You are obliged to define the medical necessity for the service in your documentation.
- This is especially important in our diagnostic and Interventional Services.
- The medical necessity should be clearly stated and adhere to the standards set by the appropriate specialty governing bodies and/or the payer.

Medical Necessity

- Even though we adhere to the standards set by the Society's as a whole, services still may not be considered for payment.
- A combination of Specific ICD 10 codes and narrative documentation in the HPI and treatment plan

Medical Necessity

- The coders are sending back testing orders if they do not meet this medical necessity.
- Notes with testing orders should be completed and signed by the provider timely.
- From CMS- If the orders and the progress notes are unsigned, a claims reviewer will disregard the order, and your facility or practice will be assessed an error, which may involve recouping an overpayment.

Documentation

- Documentation is what supports the medical necessity of the service.
- Documentation is authenticated by the provider with their Signature, electronic or otherwise.

Signatures

- “Signature issues are among the biggest findings in the comprehensive error rate testing (CERT) and medical error rate programs
- Medicare requires that services provided or ordered be authenticated by the author signature.
- Unsigned documentation or a lack of attestation will result in a claim denial, she noted. “

signatures

- If the signature is missing from an order, MACs, SMRC, and CERT **shall disregard the order** during the review of the claim (e.g., the reviewer will proceed as if the order was not received).

Orders

- For every test or procedure, there **MUST** be a signed order.

Example of invalid order

- Office visit 04/19/2018
- During the visit the Doctor orders an Art dup which is scheduled for 04/21/2018.
- The note is not signed yet on the day of the test.
- If this test happens to be pulled for audit, they would likely consider this invalid and not medically Necessary.

These are not my rules , but they are CMS rules.

CMS Probe Audit

- Each encounter has the following sent:
- Testing report
- Testing order
- Visit note on which the order is based.
- Credentials of the Provider reading the test, and credentials of the technologist performing the test.

Pitfalls

1. Verbal orders that were not documented, thus not available.

2.Testing scheduled as a bilateral but ordered as unilateral.

1. When you discover such errors in yoru practice establish corrective actions, and audit again.

2. If not you will become a practice subject to Preauthorization on every minor test.

Coding Support

- Must have
- **Must be empowered within the practice**

Compliance expectations from OIG

- These are the minimum standards the OIG expects each practice to audit
- Coding and Billing
- Medical Necessity
- Documentation

Summary

- CMS AUC is not focused on advanced imaging but likely to expand.
- Societal AUC's are scientifically sound and clinical evidence based tools to keep us from over or under utilization
- Medical Necessity criteria are set by LCD's and Commercial Payors and are usually less liberal than societal AUC's

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Thank You

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Demographics	D-RAF
82 y/o Woman	0.557
Medicaid eligible	0.179
Total RAF score	0.736
PMPM payment	$454
Approx. amount available for care	$5,500