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PBN Perspectives

CMS Primary Flex offers $250K, prospective payments to some PCP ACOs

CMS' health equity and primary care missions combine in a new accountable care organization (ACO) demonstration model offering quarter-million-dollar upfront payment to "low revenue" PCPs.

The Primary Flex ACO model was announced by CMS' Center for Medicare and Medicaid Innovation (CMMI) on March 19. The five-year program will be available to appropriate Medicare Shared Savings Program (MSSP) ACOs and will launch in 2025. Primary Flex will, in addition to giving participating providers an up-front lump sum of $250,000, pay for primary care services prospectively. The providers must in turn "use more innovative, team-based, person-centered and proactive approaches to care," according to a CMS fact sheet.

The size of the prospective payments, also known as prospective primary care payments (PPCP), will be determined for each entrant using a formula that involves a "county base rate," determined by "average primary care spending (before social and clinical risk factors are applied)" in that jurisdiction. To these rates will be added "payment enhancements" to provide a "flexible, predictable revenue stream."

The program is limited to MSSP participants that are also "low revenue" ACOs — that is, those with annualized fee-for-service revenue that amounts to less than 35% of total Part A and Part B fee-for-service expenditures for assigned beneficiaries. CMS suggests these will "tend to be mainly made up of physicians and might include a small hospital or serve rural areas," and calls it an "attractive option to ACOs with

Federally Qualified Health Center and Rural Health Clinic participants." (Since FQHCs and RHCs are not fee-for-service models, their PPCPs will be altered to reflect that, CMS suggests.)

As to the equity angle, CMS says it hopes the extra payment and primary care emphasis will help defeat "entrenched patterns of inappropriately low spending for underserved areas and populations." And, as with all such models, CMS expects to increase quality of care as well as save money with Primary Flex: "Access to high-quality primary care also can narrow disparities in health outcomes and lower the total cost of care."

What their $250K buys

ACOs that opt for and are accepted as Primary Flex participants will remain Shared Savings ACOs as well. While their county base rate payments under Flex will be factored into their usual shared risk and savings calculations, it will not be reconciled against actual claims expenditures, and their PPCPs will not be subject to program risk.

But that doesn't mean the money comes without strings. Applicants will have to submit a spend plan "with percentage allocation to spend categories, subcategories, and types … to ensure the majority of funds are spent on permitted uses related to the provision and support of advanced primary care." Participants will be required to file reports showing that they've stuck to the plan.

Prior PCP projects

CMS and CMMI have been experimenting in this vein for a few years. From 2018 through 2021, for example, CMMI ran a Comprehensive Primary Care Plus program (CPC+) that offered a monthly "care management fee" and "performance-based incentive payments" as well as regular payments under the Medicare physician fee schedule (*PBN blog 5/17/17*).

In 2019 CMMI opened its Primary Care First program as part of a Primary Cares Initiative that also included the Direct Contracting program that later became ACO REACH (*PBN 12/2/19*, *3/7/22*). Primary Care First offers "a simplified total monthly payment" for meeting "easily understood, actionable outcomes" in primary care, especially with regard to treatment of seriously ill populations (SIP).

In July 2024 CMMI will launch its Making Care Primary (MCP) Model, a multipayer project which over its 10-and-a-half-year span will gradually introduce "prospective, population-based payments while building infrastructure to improve behavioral health and specialty integration and drive equitable access to care."

Will it work?

Response from stakeholders and outside observers has been generally positive. Clif Gaus, president and CEO of the National Association of ACOs (NAACOS) praised the prospective payments as a source of the "stable and predictable cash flow needed to transform care delivery and provide comprehensive, team-based care."

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***PART B NEWS* TEAM**

Maria Tsigas, x6023
Product Director
maria.tsigas@hcpro.com

Marci Geipe, x6022
Senior Manager, Product and Content
marci.geipe@hcpro.com

Richard Scott
Content Manager
richard.scott@hcpro.com

Roy Edroso, x6031
Editor
roy.edroso@hcpro.com

Julia Kyles, CPC, x6015
Editor
julia.kyles@hcpro.com

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Gaus hoped CMS would reconsider the exclusion of higher-revenue ACOs. But Theresa Hush, CEO and co-founder of Roji Health Intelligence in Chicago, finds the current limitation appropriate: Low-revenue ACOs, she says, "are often physician-led, tend to be bootstrapped and lacking data and infrastructure to empower more targeted and data-driven interventions. Although health equity has emerged as a major goal for ACOs, screening capabilities in practices and ACO referral sources for social services have been obstacles. The combination of advance payments and predictable revenues should contribute to the resources they need to improve patient services and advance health equity."

However, Hush is concerned about the long-term efficacy of prospective payments for primary care as a cost-saving measure, which CMS expects to see from this model. "The use of population-based payments to control total cost of care has historically failed, as in the era of HMOs, marked by denial of services to keep within the capitation payment level," she says. In fact, a study of the CPC+ model appearing in the Dec. 15, 2023, edition of JAMA says that the five-year program "was found not to be associated with reductions in total expenditures."

Hush recommends "additional support to these ACOs to guide them with technology changes, practice transformation and practice teams, specialty care arrangements, and improvement programs. Guidance in resolving health-related social services will also be necessary to achieve reductions in avoidable and actual costs."

CMS says it "intends to release" the ACO PC Flex Model Request for Applications (RFA) in the second quarter of 2024 and that the applications will be due back in early August 2024. MSSP applications will be accepted between May 20 and June 17, 2024; new applicants can check a box to also apply for ACO PC Flex. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- CMS/CMMI fact sheet, "ACO Primary Care Flex," March 19, 2024: *www.cms.gov/priorities/innovation/innovation-models/aco-primary-care-flex-model*
- JAMA, "The Comprehensive Primary Care Plus Model and Health Care Spending, Service Use, and Quality," Dec. 15, 2023: *https://jamanetwork.com/journals/jama/fullarticle/2813197*

Coding

For clean screening claims, review service modifiers GG, PT and 33

Sections of the Affordable Care Act (ACA) amend the Social Security Act by requiring changes in payment and patient responsibility for deductible and coinsurance/copayments for certain preventive services, such as bone mass measurement, diabetes screening and mammography screenings.

Additional preventive services, identified for coverage through national coverage determinations, are also covered.

The ACA waives the deductible and coinsurance/copayment for many of the preventive services because those services have a recommendation grade of A or B by the U.S. Preventive Services Task Force (USPSTF).

Several preventive services covered by Medicare do not have a USPSTF recommendation grade of A or B (e.g., digital rectal examinations provided as prostate screening tests, glaucoma screening, DSMT services, and barium enemas provided as colorectal cancer screening tests).

The deductible continues to apply to the other services, as do coinsurance/copayment, according to USPSTF.

For certain services, clarity is needed to illustrate when the preventive screening services are planned but result in diagnostic services, which is when you would turn to the following modifiers:

- **GG** (Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day).
- **PT** (Colorectal cancer screening test; converted to diagnostic test or other procedure).
- **33** (Preventive services).

Modifier GG: Screening and diagnostic

Per the Medicare Preventive Services webpage, modifier GG is used to indicate that both a screening mammography and a diagnostic mammography were appropriately performed on the same patient on the same day. The modifier is appended to the diagnostic code to show that the test changed from a screening test to a diagnostic test. Most payers will allow both the screening and diagnostic mammography tests to be reported.

Submit this modifier with diagnostic mammography codes when the interpretation of a screening mammogram results in the ordering of a diagnostic mammogram on the same day. Both the screening and diagnostic tests will be reimbursed.

Mind modifier GG tips

This modifier is for informational purposes only. Submit any other applicable modifiers first, then the HCPCS modifier GG. Do not use this modifier when the mammographies are performed on different dates.

Do not use this modifier when a mammography is performed because the initial film was of poor quality or if there was a problem with performing the initial study. If a diagnostic mammography is converted from a screening mammography (not two distinct services), append modifier **GH** (Diagnostic mammogram converted from screening mammogram on same day) on the diagnostic mammography code and do not report a screening code.

Medicare allows additional mammogram films to be performed without an additional order from the treating physician.

When the radiologist's interpretation of screening mammography results in the performance of diagnostic mammography on the same day for the same patient, both tests will be reimbursed.

The American College of Radiology recommends that providers submit claims for screening and diagnostic mammography code pairs with modifier GG added to the diagnostic mammography code for tracking purposes and modifier **59** (Distinct procedural service) added to the screening mammography code to bypass current National Correct Coding Initiative (NCCI) edits.

Modifiers 33 and PT: Know the difference

Modifiers 33 and PT are similar in that they are used to indicate to payers that the service being billed either began as or was completely a screening service. These modifiers are used when the HCPCS code does not describe the service as a screening.

Modifier 33 is not recognized by Medicare (which requires modifier PT) except when billing professional fee services (not outpatient hospital) for anesthesia in conjunction with screening colonoscopies or when billing for advance care planning CPT codes:

- **99497** (Advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified healthcare professional; first 30 minutes, face-to-face with the patient, family member[s], and/or surrogate).
- Add-on code **99498** (… ; each additional 30 minutes).

In those circumstances, Medicare wants modifier 33 instead of PT. If you are billing a non-Medicare payer, check with the payer to see if it follows Medicare guidelines. Modifiers 33 and PT are used when the primary purpose of the service is delivery of:

- An evidence-based service in accordance with a USPSTF Force A or B rating.
- Other preventive services identified in preventive services mandates (legislative or regulatory).

When these circumstances exist, append the modifier to the procedure code to alert the payer that the service was converted to or began as a screening service. The payer will then remove the patient responsibility of cost-sharing as dictated by the ACA.

If a service is inherently preventive, such as a screening colonoscopy (for Medicare, there are specific HCPCS codes for screening), the modifier should not be appended because it will be clear to the payer that the service is a screening. The modifier is typically appended to codes that can be either preventive or diagnostic, e.g., code **80061** (Lipid panel).

Consider an example

A 45-year-old male received a cholesterol-screening test during a clinic visit. The patient was not shown to have high cholesterol previously, but he has a family history of high cholesterol. In this example, CPT code 80061 is reported with modifier 33 to notify the payer that it is a preventive service.

There are instances where a service begins as a screening test but due to findings during the screening, the service then becomes a diagnostic procedure. Append one of these modifiers (33 or PT) to the diagnostic code to alert the payer that the test began as a screening service.

Consider another example

You should append the modifier to the diagnostic procedure code that is reported instead of to the screening HCPCS code.

(continued on p. 6)

Benchmark of the week

Lesion-destruction codes top list of 59-appended services; labs lose

For the second year running, providers turned to modifier **59** (Distinct procedural service) most often when performing a lesion-destruction service, and denials held steady for codes **17003** and **17000**. But keep an eye on a duo of lab codes: the denial rates on **87798** and **87481** shot up significantly in 2022.

The top 20 CPT and HCPCS codes reported with modifier 59 remained largely the same in 2022 as they did the previous year, according to the latest available Medicare claims data. Only one new service — code **97110** (Therapeutic procedure, 1 or more areas, each 15 minutes) — entered the list of the 20 most-reported codes appended with 59, and it joined several other therapeutic services, including **97140** and **97530**. The lesion-destruction services held onto two of the three top spots, mirroring the 2021 claims reporting numbers, and both procedures saw an increase in total services, with 17003-59 topping 4.5 million claims in 2022, up from 4.3 million claims in 2021. The denial rate on the 17003-59 combo moved up a tick from 2.7% in 2021 to 2.8% in 2022.

The same isn't true for lab-testing codes 87798 and 87481. In 2022, the denial rate on 87798-59 jumped to 21.4%, up from 12.5% a year earlier. And 87481-59 claims returned a 16.8% denial rate in 2022, about five points more than the 11.9% rate in 2021. No other services in the top 20 saw more than a negative 3% shift year-to-year, with the next closest being alcohol screening service **G0442,** which moved from 10.9% in 2021 to 13.7% in 2022. Therapy codes, including the new entrant 97110, saw a denial-rate move in the positive direction in 2022. — *Richard Scott* (*richard.scott@decisionhealth.com*)

Top 20 codes reported with modifier 59, 2022, with claims data and denial rates

Code	Short descriptor	Modifier	Services	Denials	Denied amount	Payment	Denial rate (2022)	Denial rate (2021)
17003	Destruct premalg les 2-14	59	4,531,732	125,549	$2,676,631	$22,083,674	2.8%	2.7%
87798	Detect agent nos dna amp	59	3,615,238	772,973	$53,545,687	$98,454,331	21.4%	12.5%
17000	Destruct premalg lesion	59	2,172,064	60,425	$8,844,494	$54,251,578	2.8%	2.8%
G0444	Depression screen annual	59	1,376,513	211,643	$7,975,302	$19,566,928	15.4%	15.5%
96372	Ther/proph/diag inj sc/im	59	1,163,166	90,301	$4,708,290	$11,395,449	7.8%	9.0%
11721	Debride nail 6 or more	59	1,018,290	82,505	$6,951,841	$31,911,278	8.1%	8.3%
93000	Electrocardiogram complete	59	991,554	64,077	$3,832,373	$9,721,020	6.5%	6.3%
87150	Dna/rna amplified probe	59	951,912	101,519	$6,434,246	$29,409,080	10.7%	12.0%
11102	Tangntl bx skin single les	59	851,744	27,278	$5,699,948	$42,430,209	3.2%	3.1%
87481	Candida dna amp probe	59	812,544	136,735	$9,603,476	$23,395,165	16.8%	11.9%
97140	Manual therapy 1/> regions	59	720,510	316,440	$15,491,777	$6,796,193	43.9%	48.9%
93010	Electrocardiogram report	59	709,283	75,149	$5,061,504	$4,038,591	10.6%	9.2%
97530	Therapeutic activities	59	647,047	56,090	$4,045,213	$15,828,606	8.7%	10.6%
G0442	Annual alcohol screen 15 min	59	569,310	77,721	$2,826,671	$8,452,678	13.7%	10.9%
J1642	Inj heparin sodium per 10 u	59	488,326	139,443	$220,047	$4,140	28.6%	31.1%
95004	Percut allergy skin tests	59	485,315	72,078	$997,755	$1,305,734	14.9%	14.0%
83721	Assay of blood lipoprotein	59	419,388	31,494	$1,370,400	$3,906,806	7.5%	7.1%
11720	Debride nail 1-5	59	395,149	27,800	$1,655,386	$9,381,257	7.0%	7.9%
17110	Destruct b9 lesion 1-14	59	339,471	12,010	$2,517,587	$23,479,581	3.5%	3.5%
97110	Therapeutic exercises	59	336,114	75,768	$4,551,481	$5,000,736	22.5%	29.2%

Source: Part B News *analysis of 2021-2022 Medicare claims data*

(continued from p. 4)

Medicare wants modifier PT only on diagnostic lower gastrointestinal endoscopies that began as a screening service. Do not use modifier PT when the service began as a diagnostic procedure or with a HCPCS code that is not a diagnostic, according to CMS' Quick Preventive Medicine Screening Chart.

CMS guidelines define a "screening colonoscopy" as follows: A colonoscopy being performed on a patient who does not have any signs or symptoms in the lower gastrointestinal anatomy prior to the scheduled test.

Any symptom such as change in bowel habits, diarrhea, constipation, rectal bleeding, anemia, etc., prior to the procedure and noted as a symptom by the physician in the medical record may change the procedure from a screening to a diagnostic colonoscopy.

Coding scenarios

Consider one scenario: A Medicare patient is having an outpatient screening colonoscopy. The patient's previous colonoscopy was 13 years ago and normal. The patient has no history of polyps or colorectal cancer, and none of the patient's siblings, parents or children has a history of polyps or colorectal cancer. The patient is eligible for a screening colonoscopy.

Reportable procedures include the following:

- **G0121** (Colorectal cancer screening; colonoscopy on individual not meeting the criteria for high risk).

The HCPCS code — not the CPT code — is the correct code to use because the patient is a Medicare patient. Additionally, code G0121 is selected because the patient is not identified as high risk.

Think about another scenario: A Medicare patient is having an outpatient screening colonoscopy. The patient's previous colonoscopy was 13 years ago and normal. The patient has no history of polyps or colorectal cancer, and none of the patient's siblings, parents, or children has a history of polyps or colorectal cancer. The patient is eligible for a screening colonoscopy. During the screening colonoscopy, a polyp is discovered and biopsied.

Reportable procedures include the following:

- **45380**-PT (Colonoscopy, flexible; with biopsy, single or multiple).

Because there was a finding during the screening procedure, the service is coded as a diagnostic colonoscopy with biopsy along with modifier PT to indicate that the procedure began as a screening service. — *Decision Health staff* (*pbnfeedback@decisionhealth.com*) ■

Editor's note: *Information for this article was adapted from* JustCoding's Guide to Modifiers: Hospital Outpatient Edition, Third Edition. *Learn more: https://hcmarketplace.com/justcodings-guide-to-modifiers-third-edition.*

Health IT

Use AI to scribe? Pay attention to data privacy, ownership

Much discussion of artificial intelligence (AI) in health care focuses on the readiness, or lack thereof, of clinical applications. But even if you're using only the most basic AI tools, such as scribing applications, you still need to be careful about data security, integrity and privacy — and about the contract terms that allow the vendor to use your data.

The recent rapid advance of generative IT applications such as OpenAI's ChatGPT has penetrated the health care world, with various developers working to turn its power on patient diagnosis and treatment (*PBN 2/5/24*). Most practices' first forays into AI, however, will be through tools that perform administrative tasks, such as those that use the technology to improve patient encounter note-taking, aka the scribing function. Products like DeepScribe, Dax CoPilot and Augmedix have flooded the market, promising greater efficiency and accuracy in recording and transcription via "ambient listening."

Sara Helene Shanti, a health care partner at the Sheppard Mullin law firm in Chicago, says in many ways AI scribes "are similar to other mainstream technologies and share universal best practices." But it's possible that patients will want to know when this new tech is involved in their doctors' appointment. They may even be concerned by what they've read about AI's ominous attributes and have questions about its use.

Shanti considers informing patients of AI involvement as a best practice — though she acknowledges that, as its use proliferates, it's "going to be more and more difficult to identify every software program or piece of equipment that potentially has an AI component."

The AMA has an extensive "Principles for Augmented Intelligence Development, Deployment, and Use" document. Amy M. Joseph, a partner with Hooper Lundy Bookman in Boston, points out that the AMA recommends that "[w]hen AI is utilized in health care decision-making, that use should be disclosed and documented in order to limit risks to, and mitigate inequities for, both physicians and patients, and allow each to understand how decisions impacting patient care or access to care are made."

To the extent that this applies to AI in scribing, it would be at the very low end of that care continuum. But it still involves the handling of patient data. "Erring on the side of transparency builds critical patient trust that can lead to improved outcomes and mitigated liability," Shanti says.

Getting the patient comfortable

As with any recording tool, you should get either written or verbal consent ahead of time, Shanti recommends. And it may be reassuring to your more concerned patients if you can describe how the technology is used, and how it might be even less of a security risk than other recording methods.

Paul F. Schmeltzer, a health care attorney with Clark Hill in Los Angeles, notes that, for example, NextGen's Ambient Assist uses AI to put a transcribed version of the conversation into SOAP note format for the provider to review, edit and incorporate into the chart. But once the provider sends it to the EHR, it's deleted. "Only the clinical portion of the conversation is left after the application scrubs the transcription," he says.

As to how technical you get with the patient, "as with any patient disclosure or consent process, clinicians should use their reasoned judgment," Joseph says. However, "while transparency with patients is never a bad thing, if content is too technical it can be viewed as legal jargon that individuals are more likely to skip over, and therefore less effective," she adds.

That might ease the patient's mind. It may also be helpful to note that health care AI vendors sign business associate agreements (BAA) with providers that outline their responsibilities under HIPAA privacy and security laws. While this doesn't alleviate the provider's ultimate responsibility, it does demonstrate mutual awareness of legal requirements owed to safeguarding patient information and penalties for failing to do so.

Also, as you probably already do with any computer-transcribed patient recording, you'll be reviewing the AI transcript. The AMA says that "AI tools or systems cannot augment, create, or otherwise generate records, communications, or other content on behalf of a physician without that physician's consent and final review."

De-identified data rights

Though it's not directly a privacy concern, experts should be attentive to any item in their contracts with AI vendors concerning "de-identified" patient data, to which some vendors may require access so that they can build their language models and improve the responsiveness and relevance of their tools' results.

"We are seeing significant negotiations as part of the contracting process between providers and vendors that provide an AI tool, particularly with respect to the ability to de-identify the customer's PHI [protected health information] and utilize to further build upon and improve the tool," Joseph says.

HHS allows de-identified PHI to be used commercially because it can't be traced back to specific patients. The agency offers extensive guidance which, among other things, states that "the Privacy Rule does not limit how a covered entity may disclose information that has been de-identified." (*See resources, below.*)

Still, providers may consider negotiating those terms, given the worth of that data. "Even when compliance and ethics are cleared, there remain business implications in allowing or prohibiting a vendor to use what can be extremely valuable data, even de-identified and derivative of health information," Shanti says.

Or, if you have the bandwidth, you may want to handle the de-identiying job yourself, says Bryant Robinson, principal with Sendero Consulting in Dallas. "I've also seen health systems reach out to third-party vendors that specialize in the de-identification of [patient] data," Robinson says.

Under the right circumstances you could conceivably monetize your own de-identified data. "We are also seeing data license agreements more frequently where a charge is incurred for the license of the de-identified data, and the licensor is also able to place contractual protections in place, such as limiting the use of the licensed data to a defined purpose," Joseph says. If you feel you have the leverage — or are willing to work with multiple vendors until you find one that's accommodating — you may get the benefits at a lower price. — *Roy Edroso* (*roy.edroso@decisionhealth.com*) ■

RESOURCES

- AMA, "Principles for Augmented Intelligence Development, Deployment, and Use," Nov. 14, 2023: *www.ama-assn.org/system/files/ama-ai-principles.pdf*
- HHS, "Guidance Regarding Methods for De-identification of Protected Health Information in Accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule," last reviewed Oct. 25, 2022: *www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html*

Billing

MACs take another crack at the uniform LCD for facet joint interventions

Get ready for another update to your local coverage determination (LCD) for facet joint interventions. Medicare administrative contractors (MAC) are teaming up again to clarify their uniform LCD for facet joint nerve blocks (**64490-64491** and **64493-64494**) and radiofrequency ablation (RFA) (**64633-64636**).

All seven MACs are revisiting their LCDs with an eye toward tightening up their rules for anesthesia with facet joint interventions and third and fourth level blocks and to formally turn down a request to expand coverage of therapeutic blocks.

For example, CGS, Noridian and Palmetto's proposed LCDs have the following document note:

"This LCD is being taken to the open meeting for clarification regarding non-coverage of 3rd level injection, use of anesthesia in conjunction with facet injections and RFA and a request for expansion of therapeutic joint injection as a first line option. Otherwise, the LCD is not open for official comment."

Based on a comparison of Palmetto GBA's current and proposed LCD, the MACs plan to eliminate coverage of monitored anesthesia care, moderate sedation, deep sedation and general anesthesia for facet blocks and aspiration or rupture of facet cysts. In addition, the MACs provide more details on the type of conditions that might justify anesthesia with RFA procedures. The chart below provides a side-by-side comparison of current and proposed policy language.

The MACs will expect "documentation of medical necessity such as a longstanding well-documented history of inability to cooperate, medical conditions that would prohibit performance of the procedure, or inability to remain motionless." The proposed language suggests MACs will look at the patient's claims history for diagnoses that support the anesthesia provider's diagnosis. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

Current policy	Proposed policy
General anesthesia is considered not reasonable and necessary for facet joint interventions. Neither conscious sedation nor monitored anesthesia care (MAC) is routinely necessary for IA facet joint injections or MBBs and are not routinely reimbursable. Individual consideration may be given on redetermination (appeal) for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.	Use of moderate or deep sedation, general anesthesia, and monitored anesthesia care (MAC) is not considered medically reasonable and necessary during facet procedures of IA, MBB, and facet cyst aspiration/rupture. The use of moderate anesthesia for RFA will be considered in individual cases with documentation of medical necessity such as a longstanding well-documented history of inability to cooperate, medical conditions that would prohibit performance of the procedure, or inability to remain motionless. Patient anxiety or preference alone is not sufficient justification. Routine use of moderate sedation or MAC or use of general anesthesia or deep sedation for RFA is not considered reasonable and necessary.
The need for a 3 or 4 level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal.	Three or 4-level procedures are not medically necessary and therefore are non-covered.