mln MATTERS®
KNOWLEDGE • RESOURCES • TRAINING

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements

MLN Matters Number: MM11268 Revised
Related Change Request (CR) Number: 11268
Related CR Release Date: December 6, 2019
Effective Date: January 1, 2020
Related CR Transmittal Number: R2404OTN
Implementation Date: January 6, 2020

Note: We revised this article on December 9, 2019, due to an updated Change Request (CR). The updated CR removes codes that are not available for 2020. In addition, codes have been added to the attachment in the CR that serves to replace some of the expired codes. Removed codes include: 77058, 77059, 78205, 78206, 78270, 78271, 78272, 78320, 78607, 78647, 78710, 78805, 78806, 78807. Added codes include: 77048, 77049, 78429, 78430, 78431, 78432, 78433, 78434, 78830, 78831, 78832, 78835. The CR release date, transmittal number and link to the transmittal also changed. All other information remains the same.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians, providers and suppliers billing Medicare Administrative Contractors (MACs) for services provided to Medicare beneficiaries.

WHAT YOU NEED TO KNOW

CR11268 informs MACs that, effective on January 1, 2020 (the start of the AUC program Educational and Operations Testing Period), they should accept the Appropriate Use Criteria (AUC) related HCPCS modifiers on claims. Please be sure your billing staff and vendors are aware of this update. Subsequent CRs will follow at a later date that will continue AUC program implementation.

BACKGROUND

The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b), established a new program to increase the rate of appropriate advanced diagnostic imaging services furnished to Medicare beneficiaries. Examples of advanced imaging services include:

- Computed tomography
- Positron emission tomography
- Nuclear medicine
- Magnetic resonance imaging

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES
Medicare Learning Network®

Under this program, when an advanced imaging service is ordered for a Medicare beneficiary, the ordering professional will be required to consult a qualified Clinical Decision Support Mechanism (CDSM). A CDSM is an interactive, electronic tool for use by clinicians that communicates AUC information to the user and assists them in making the most appropriate treatment decision for a patient's specific clinical condition during the patient's workup. The CDSM will provide the ordering professional with a determination of whether that order adheres to AUC, does not adhere to AUC, or if there is no AUC applicable (for example, no AUC is available to address the patient's clinical condition) in the CDSM consulted.

When this program is fully implemented at a future date, a consultation must take place for any applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid under an applicable payment system and information related to the consultation must be appended to claims.

Note: The applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered.

Applicable settings include:

- Physician offices
- Hospital outpatient departments (including emergency departments)
- Ambulatory Surgical Centers (ASCs)
- Independent diagnostic testing facilities

Applicable payment systems include:

- Physician Fee Schedule (PFS)
- Hospital Outpatient Prospective Payment System
- ASCs

Voluntary participation was established for this program from July 1, 2018, through December 31, 2019. CR 10481 discusses the voluntary participation period. The related MLN article may be read at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10481.pdf. This CR contains information related to the Educational and Operations Testing Period which is expected to last for one year (January 1, 2020 – December 31, 2020). Full program implementation is expected January 1, 2021. At that time, information regarding the ordering professional's consultation with CDSM, or exception to such consultation, must be appended to the furnishing professional's claim in order for that claim to be paid.

Exceptions to consulting CDSMs include:

- The ordering professional having a significant hardship
- Situations in which the patient has an emergency medical condition
- An applicable imaging service ordered for an inpatient and for which payment is made under Part A

Ultimately, PAMA requires that the program results in prior authorization for ordering professionals that are identified as having outlier-ordering patterns. **Before the prior authorization component of this program begins, there will be notice and comment rulemaking to develop the outlier methodology.**

AUC Policy

Regulatory language for this program is in 42 Code of Federal Regulations (CFR), Section 414.94, titled, "Appropriate Use Criteria for Advanced Diagnostic Imaging Services." In the Calendar Year (CY) 2018 Physician Fee Schedule final rule, CMS stated that this program will be implemented in 2020, with an Educational and Operations Testing Period.

During this phase of the program claims will not be denied for failing to include AUC-related information or for misreporting AUC information on non-imaging claims (for example, failure to include one of the below modifiers and/or one of the below G codes or reporting modifiers on the wrong claim line or for the wrong service), but inclusion is encouraged.

Also, the claims processing systems will be prepared by January 1, 2020, to accept claims that contain a Current Procedural Terminology (CPT) or HCPCS C code, for advanced diagnostic imaging along with a line item HCPCS modifier to describe either the level of adherence to AUC or an exception to the program and a separate line item G-code to identify the qualified CDSM consulted.

During CY 2020, CMS expects ordering professionals to begin consulting qualified CDSMs and providing information to the furnishing practitioners and providers for reporting on their claims. Situations in which furnishing practitioners and providers do not receive AUC-related information from the ordering professional can be reported by modifier MH. Even though claims will not be denied during this Educational and Operations Testing Period, inclusion is encouraged.

The following HCPCS modifiers have been established for this program for placement on the same line as the CPT code for the advanced diagnostic imaging service:

- 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)

Claims that report HCPCS modifier ME, MF, or MG on the Advanced Diagnostic Imaging Services **claim line should additionally contain a G-code (on a separate claim line) to report which qualified CDSM was consulted (NOTE: Multiple G codes on a single claim is acceptable.):**

- 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

Since G-codes do not have associated payment rates (e.g. they are not payable codes and are only used for reporting), it is expected that your MAC will appropriately adjudicate a no-pay G-code line-item and use the following message:

- CARC 246 -This non-payable code is for required reporting only
- RARC N620 Alert - This procedure code is for quality reporting/informational purposes only

Note: Although these codes are not associated with a payment rate there may be circumstances when a nominal charge amount may be necessary for operational reasons related to claims processing. The beneficiary is not responsible for the denied charge.

Medicare Appropriate Use Criteria Program for Advanced Diagnostic Imaging – Code List

HCPCS Advanced Imaging Procedure Codes

Magnetic Resonance Imaging/Magnetic Resonance Angiography
70336, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 71550, 71551, 71552, 71555, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72195, 72196, 72197, 72198, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74181, 74182, 74183, 74185, 75557, 75559, 75561, 75563, 75565, 76498, 77046, 77047, 77048, 77049

Computerized Tomography
70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74261, 74262, 74712, 74713, 75571, 75572, 75573, 75574, 75635, 76380, 76497

Single-Photon Emission Computed Tomography

76390

Nuclear Medicine
78012, 78013, 78014, 78015, 78016, 78018, 78020, 78070, 78071, 78072, 78075, 78099, 78102, 78103, 78104, 78110, 78111, 78120, 78121, 78122, 78130, 78135, 78140, 78185, 78191, 78195, 78199, 78201, 78202, 78215, 78216, 78226, 78227, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78265, 78266, 78267, 78268, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78350, 78351, 78399, 78414, 78428, 78429, 78430,

78431, 78432, 78433, 78434, 78445, 78451, 78452, 78453, 78454, 78456, 78457, 78458, 78459, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78491, 78492, 78494, 78496, 78499, 78579, 78580, 78582, 78597, 78598, 78599, 78600, 78601, 78605, 78606, 78608, 78609, 78610, 78630, 78635, 78645, 78650, 78660, 78699, 78700, 78701, 78707, 78708, 78709, 78725, 78730, 78740, 78761, 78799, 78800, 78801, 78802, 78803, 78804, 78811, 78812, 78813, 78814, 78815, 78816, 78830, 78831, 78832, 78835, 78999

C-codes
C8900, C8901, C8902, C8903, C8905, C8908, C8909, C8910, C8911, C8912, C8913, C8914, C8918, C8919, C8920, C8931, C8932, C8933, C8934, C8935, C8936

ADDITIONAL INFORMATION

The official instruction, CR11268, issued to your MAC regarding this change, is available at https://www.cms.gov/files/document/R2404OTN.

Institutional claim providers do not have the capability to report line level ordering physician information on the institutional claim at this point. CMS is working with industry partners and will provide additional instructions on reporting line level ordering physician information for institutional claims at a future date.

Additional information regarding the AUC program is available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index.html.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

DOCUMENT HISTORY

Date of Change	Description
December 9, 2019,	We revised this article due to an updated CR. The updated CR removes codes that are not available for 2020. In addition, codes have been added to the attachment in the CR that serves to replace some of the expired codes. Removed codes include: 77058, 77059, 78205, 78206, 78270, 78271, 78272, 78320, 78607, 78647, 78710, 78805, 78806, 78807. Added codes include: 77048, 77049, 78429, 78430, 78431, 78432, 78433, 78434, 78830, 78831, 78832, 78835. The CR release date, transmittal number and link to the transmittal also changed
July 26, 2019	Initial article released.