CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2425	**Date: January 31, 2020**
	Change Request 11571

SUBJECT: Implementation of Usage of the K3 Segment for Reporting Line Level Ordering Provider on Institutional Claims for Advanced Diagnostic Imaging

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to implement the usage of the K3 segment for transmitting ordering provider information as part of Appropriate Use Criteria (AUC) for Advance Diagnostic Imaging.

EFFECTIVE DATE: January 1, 2020
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: July 6, 2020

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 2425	Date: January 31, 2020	Change Request: 11571

SUBJECT: Implementation of Usage of the K3 Segment for Reporting Line Level Ordering Provider on Institutional Claims for Advanced Diagnostic Imaging

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I. GENERAL INFORMATION

A. 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, and magnetic resonance imaging. Under this program, at the time 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 Appropriate Use Criteria (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 workup. There may be modules within or available through certified Electronic Health Record (EHR) technology, private sector mechanisms independent from certified EHR technology, or those established by the Centers for Medicare & Medicaid Services (CMS). 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 (e.g., no AUC is available to address the patient's clinical condition) in the CDSM consulted. The consultation information must then be provided to the furnishing professional and furnishing facility for inclusion on their Medicare claims.

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

B. Policy: Regulatory language for this program is in 42 CFR 414.94 titled Appropriate Use Criteria for Advanced Diagnostic Imaging Services. In the Calendar Year (CY) 2018 PFS final rule, CMS said this program would 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 (e.g., failure to include one of the below modifiers and/or one of the below G codes or reporting modifiers on the wrong line or wrong service), but inclusion is encouraged. In addition, the claims processing systems will be prepared by January 1, 2020, to accept claims that contain a Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (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 G-code to identify the qualified CDSM consulted.

During CY 2020, we expect 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 as it is important for CMS to track this information.

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

Claims that report HCPCS modifier ME, MF, or MG should additionally contain a G code to report which qualified CDSM was consulted.

For institutional 837I electronic claims, the K3 segment has been approved for usage in reporting the line-level ordering provider for the AUC program.

When reporting the Ordering Provider National Provider Identifier (NPI), the K3 will use the following values for each service line that needs an Ordering Provider reported:

AUC represents the program

LX represents the service line followed by the service line number reported in LX01

DK represents the Ordering Provider identifier followed by the Ordering Provider's NPI

If an Ordering Provider NPI is the same for multiple service lines, each service line must be reported separately in the K301. The K301 supports 80 characters, which may allow up to four Ordering Provider NPI iterations in a single K301 data element. Additional K3 segments can be sent as needed (up to a maximum of ten K3 segments), but each one must begin with the value of AUC as shown below.

K3 Examples:

Reporting 1 Ordering Provider NPI

K3*AUCLX1DK1111111111~

Reporting 5 Ordering Provider NPIs

K3*AUCLX1DK1111111111LX11DK9999999999LX22DK1111111111LX433DK2222222222~

K3*AUCLX444DK4444444444~

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
11571.1	The Shared System shall create a new line level field to capture the ordering provider information for the AUC program for Advance Diagnostic Imaging in the outpatient claim record. This field shall be available for Direct Data Entry (DDE) use by providers and contractors.	X				X				
11571.1.1	FISS shall pass this line level information to downstream systems and these downstream Shared System Maintainers and systems shall create a new field to capture and store the ordering provider					X	X		X	FPS, IDR, NCH

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	information from institutional claims. This includes updating the OUTH for the outpatient claim history screen in the Health Insurance Master Record (HIMR) record in CWF. **NOTE:** NCH can add the new field (Ordering NPI) to the line level with our Version 'L' changes but the data will not be stored in the NCH until the January 4, 2021 implementation. NCH will make modifications to the front-end MQR input copybook (what we receive from CWF) with the July 2020 release so we have no issues with what we receive from CWF once they implement the change, the data will not be forwarded to the NCH until we implement Version 'L'.									
11571.2	Medicare contractors shall allow effective for claims with dates of service on or after January 1, 2020, on the Uniform Billing (UB)-04 paper claims, the Ordering Provider is reported in Form Locator (FL) 43, and insert this information in the newly created claim field for ordering provider when appended to an advance diagnostic imaging service.	X								
11571.3	The Medicare contractors and Shared System Maintainers shall allow effective for claims with dates of service on or after January 1, 2020, on the 837I electronic claim the Ordering Provider the K301 data element reported as follows: • K3 represents the segment • AUC represents the program • LX represents the service line followed by the service line number reported in LX01 • DK represents the Ordering Provider identifier followed by the Ordering Provider's NPI **Note:**	X				X				

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	K3 Example Reporting 1 Ordering Provider NPI : • K3*AUCLX1DK1111111111~ K3 Example Reporting 5 Ordering Provider NPIs: • K3*AUCLX1DK1111111111LX11DK9999999999LX22DK1111111111LX433DK2222222222~ • K3*AUCLX444DK4444444444~									
11571.4	The Shared System Maintainer shall map the K301 data element from the 837I to the to the new line level Ordering provider NPI for the line reported in the LX on AUC claims with Advance Diagnostic Imaging services.					X				
11571.5	The Shared System Maintainer shall create a K3 segment(s) including all line level Ordering Provider NPIs associated with the claim, and include the K3 segment(s) in the Coordination of Benefits Agreement Crossover claim.					X				BCRC

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Fred Rooke, fred.rooke@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0