CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2404	**Date: December 6, 2019**
	Change Request 11268

Transmittal 2323, dated July 26, 2019, is being rescinded and replaced by Transmittal 2404 dated, December 6, 2019. This correction removes codes that are not available for 2020. In addition, codes have been added to the attachment 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. All other information remains the same.

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

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform the Medicare Administrative Contractors (MACs) that effective January 1, 2020, MACs should accept the Appropriate Use Criteria (AUC) related HCPCS modifiers on claims.

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

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

EFFECTIVE DATE: January 1, 2020
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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 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.

Priority clinical areas are defined in 42 CFR 414.94(b) as clinical conditions, diseases or symptom complexes and associated advanced diagnostic imaging services identified by CMS through annual rulemaking and in consultation with stakeholders. Please note that AUC consultation is required for all advanced diagnostic imaging services, not just those within the priority clinical areas.

Current Priority Clinical Areas

•Coronary artery disease (suspected or diagnosed)

•Suspected pulmonary embolism

•Headache (traumatic and non-traumatic)

•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

When this program is fully implemented, 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. (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), and independent diagnostic testing facilities. Applicable payment systems include: the physician fee schedule (PFS), the hospital outpatient prospective payment system, and ASCs.

Voluntary participation was established for this program from July 1, 2018 through January 1, 2020. CR 10481 discusses the voluntary participation period. This CR (11268) discusses the Educational and Operations Testing Period for calendar year (CY) 2020 (see additional information below).

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 exception, situations in which the patient has an emergency medical condition, or, an applicable imaging service ordered for an inpatient and for which payment is made under Part A.

Ultimately, PAMA requires that the program result 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.

B.   Policy: Regulatory language for this program is in 42 CFR 414.94 titled Appropriate Use Criteria for Advanced Diagnostic Imaging Services. In the CY 2018 PFS Final Rule, CMS- said 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 (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. These codes are available in the Attachment.

Claims that report HCPCS modifier ME, MF, or MG should additionally contain a G code to report which qualified CDSM was consulted. The G codes are available in the Attachment.

A subsequent CR will follow at a later date that will further operationalize this AUC policy.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared-System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
11268.1	Effective for claims with dates of service on or after January 1, 2020 and until further notice, contractors shall accept the AUC-related HCPCS modifiers on the same claim line as any Advance Diagnostic Imaging HCPCS code (see attachment 1).	X	X							IOCE
11268.1.1	Contractors shall accept claims with HCPCS modifier ME, MF or MG on the Advance Diagnostic Imaging service HCPCS code along with a separate line with a G-code from the attachment to report, which qualified CDSM was consulted.	X	X							
11268.2	Contractors shall follow normal current processes when dealing with new modifiers that are reported prior to their effective dates.	X	X							
11268.3	Effective for claims with dates of services on or after January 1, 2020, contractors shall accept the presence of the AUC-related G codes (see attachment 1) on claims. **NOTE**: Multiple G codes on a single claim is acceptable.	X	X							IOCE
11268.4	The G-codes in attachment 1 (codes that identify clinical decision support mechanisms) will be assigned a PFS procedure status indicator of "X" and will be assigned an Outpatient Prospective Payment System (OPPS) status indicator of "E1". Contractors shall apply a denial message for these line item G codes. These codes are not payable.	X	X							IOCE
11268.4.1	Contractors shall deny these G codes to ensure the information is carried through to National Claims History.	X	X							IOCE
11268.4.2	Contractors shall deny the G code line item with the following messages: MSN 36.7 This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount. CARC 246 This non-payable code is for required reporting only RARC N620 Alert: This procedure code is for quality reporting/informational purposes only.	X	X							IOCE

Number	Requirement	Responsibility								
		A/B MAC			D M E MAC	Shared-System Maintainers				Other
		A	B	H H H		F I S S	M C S	V M S	C W F	
	The Group Code is CO. **NOTE**: The beneficiary is not responsible for the denied charge.									
11268.5	Contractors shall refer to Attachment 1 for a list of HCPCS procedure codes that constitute advanced diagnostic imaging services subject to the Medicare appropriate use criteria program, HCPCS modifiers to be placed on the same line as any listed or unlisted procedure code and G codes for reporting the clinical decision support mechanism.	X	X							IOCE
11268.5.1	Contractors shall be notified of updates to Attachment 1 through the quarterly issuance of a Technical Direction letter.	X	X							IOCE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E MAC	C E D I
		A	B	H H H		
11268.6	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the "MLN Matters" listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X			

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): Patricia Brocato-Simons, 410-786-0261 or Patricia.Brocatosimons@cms.hhs.gov (Coverage and Analysis Group) , Wanda Belle, 410-786-7491 or Wanda.Belle@cms.hhs.gov (Coverage and Analysis Group), JoAnna Baldwin, 410-786-7205 or JoAnna.Baldwin@cms.hhs.gov (Coverage and Analysis Group).

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: 1

Attachment 1

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

<u>**HCPCS Advanced Imaging Procedure Codes**</u>

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

<u>**HCPCS Modifiers**</u>

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)

G codes

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