



THE CMS APPROPRIATE USE CRITERIA PROGRAM

MGMA AUC Toolkit

MGMA Government Affairs has developed this toolkit to help practice leaders better understand and implement the Centers for Medicare & Medicaid Services (CMS) Appropriate Use Criteria (AUC) program.



INTRODUCTION

The Protecting Access to Medicare Act (PAMA) of 2014 included a provision seeking to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries. Examples of advanced imaging services covered under the AUC program include:

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

CMS finalized an initial list of priority clinical areas, defined by the agency as clinical conditions, diseases or symptom complexes and associated advanced diagnostic imaging services, in the CY 2017 Physician Fee Schedule Final Rule. These priority clinical areas include:

- 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

Ordering professionals will be required to consult a qualified Clinical Decision Support Mechanism (CDSM) to provide a determination of whether the order adheres to AUC, or if the AUC consulted was not applicable (e.g., no AUC is available to address the patient's clinical condition). A CDSM is an interactive, electronic tool for use by clinicians that communicates AUC information to the user and can assist them in making the most appropriate treatment decision for a patient's specific clinical condition during the patient's workup. Rendering professionals will include the AUC consultation code on their Medicare claims.

TIMELINE

The AUC program will begin Jan. 1, 2020 with a one year educational and operations testing period. For this first year, CMS will not require the AUC consultation code on advanced imaging orders nor require the AUC consultation code on Medicare claims.

Starting Jan. 2021, an AUC consultation must take place at the time of the order for imaging services that will be furnished in one of designated settings and paid for under one of the designated payment systems.

Also starting Jan. 2021, CMS will collect a minimum of two years of AUC data in order to identify up to 5 percent of ordering professionals and subject them to prior authorization requirements.

APPLICABLE CLINICAL SETTINGS AND PAYMENT SYSTEMS

An AUC consultation must take place for any applicable imaging service furnished in an applicable clinical setting.” 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
- Hospital Outpatient Prospective Payment System
- Ambulatory surgical center payment system

EXCEPTIONS

Exceptions to the requirement that an ordering professional consult a qualified CDSM include:

- The ordering professional having a significant hardship, such as
 - Insufficient Internet access.
 - EHR or CDSM vendor issues.
 - Extreme and uncontrollable circumstances.
- 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.

PENALTIES

For rendering professionals, CMS will begin rejecting claims, starting Jan. 1, 2021, that do not contain the AUC consultation code or misreport AUC information on non-imaging claims. For example, this would include failing to include one of the modifiers and/or one of the G codes or reporting modifiers on the wrong claim line or for the wrong service.

CMS will begin collecting data related to the AUC consultation codes submitted by ordering professionals on advanced imaging orders to rendering professionals. As required by PAMA, CMS will identify up to five percent of ordering professionals whose ordering patterns are considered “outliers.” These practitioners will be subject to prior authorization requirements during the advanced imaging ordering process.

CLINICAL DECISION SUPPORT MECHANISMS

PAMA requires CMS to evaluate and designate CDSMs as eligible to be used in the AUC program. These CDSMs must be developed by a provider-led entity (PLE), defined as a national professional medical specialty society or other organization that is comprised primarily of providers or practitioners who, either within the organization or outside of the organization, predominantly provide direct patient care. Once a PLE is qualified, the AUC criteria that has been developed, modified or endorsed by the PLE can be used in the AUC program.

CMS Qualified CDSMs

| | |
|--|---|
| AgileMD’s Clinical Decision Support Mechanism | Medicalis Clinical Decision Support Mechanism |
| AIM Specialty Health ProviderPortal®* | National Decision Support Company CareSelect™** (free, web-based CDSM tool) |
| Applied Pathways CURION™ Platform | National Imaging Associates RadMD |
| Cranberry Peak ezCDS | Reliant Medical Group CDSM |
| eviCore healthcare’s Clinical Decision Support Mechanism | Sage Health Management Solutions Inc. RadWise® |
| EvidenceCare’s Imaging Advisor | Stanson Health’s Stanson CDS |
| Inveni-QA’s Semantic Answers in Medicine™ | Test Appropriate CDSM* |
| MedCurrent OrderWise™ | |

CDSMs with Preliminary CMS Qualification

| | |
|--|------------------------------|
| Cerner CDS mechanism | Infinx CDSM |
| Evinance Decision Support | LogicNets’ Decision Engines |
| Flying Aces Speed of Care Decision Support | New Century Health’s CarePro |
| HealthHelp’s Clinical Decision Support Mechanism | |

SOFTWARE/BILLING REQUIREMENTS

Claims processing systems will need to accept claims that contain a Current Procedural Terminology (CPT) or Healthcare Procedural Coding System (HCPCS) C codes 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.

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

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

As 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 Medicare Administrative Contractors (MACs) 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 Medicare beneficiary is not responsible for the denied charge.

MEDICARE APPROPRIATE USE CRITERIA PROGRAM FOR ADVANCED DIAGNOSTIC IMAGING – HCPCS ADVANCED IMAGING PROCEDURE CODES

Single-Photon Emission Computed Tomography: 76390

Magnetic Resonance Imaging: 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, 77058, 77059

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

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, 78205, 78206, 78215, 78216, 78226, 78227, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78265, 78266, 78267, 78268, 78270, 78271, 78272, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78320, 78350, 78351, 78399, 78414, 78428, 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, 78607, 78608, 78609, 78610, 78630, 78635, 78645, 78647, 78650, 78660, 78699, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78730, 78740, 78761, 78799, 78800, 78801, 78802, 78803, 78804, 78805, 78806, 78807, 78811, 78812, 78813, 78814, 78815, 78816, 78999

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

PRACTICE ACTION STEPS

| | |
|--|---|
| <p>1 Determine if your clinicians that order or render advanced imaging tests will be subject to the AUC requirements.</p> | <p>10 As this is preferable, discuss with your EHR/CDSM vendor if the structured indication selected by the ordering professional will be available in their interpretation workflow.</p> |
| <p>2 Discuss with your EHR vendor if they have integrated a CMS-qualified CDSM product into their software.</p> | <p>11 For rendering professionals, develop a workflow process that incorporates an appropriate HCPCS code on Medicare claims.</p> |
| <p>3 If you have implemented a CDSM product that is not currently approved by CMS, talk to your CDSM vendor to determine if they are seeking to receive approval for use in the AUC program.</p> | <p>12 For staff of rendering professionals, ensure workflows are capable of receiving both manual and electronic orders that include the AUC consultation code.</p> |
| <p>4 If you do not have an EHR or your EHR vendor will not be incorporating one of the CMS-approved CDSMs into their software, test the free web-based CDSM tool (expected to be available in November 2019). For more information on this free tool click here.</p> | <p>13 Inform practice leadership staff of the AUC program, timelines, penalties, impact on billing and IT processes, and potential implementation costs and establish timelines and budget.</p> |
| <p>5 For ordering professionals, develop a workflow process that identifies which patients the ordering professional would need to consult the AUC software. Depending on the volume of imaging orders produced, practices may decide to consult the AUC software for all patients.</p> | <p>14 Communicate to all ordering and rendering professionals what the AUC program is, how it will impact their workflow, and the importance of compliance.</p> |
| <p>6 For ordering professionals, ensure that your CDSM includes the structured indication selected by the ordering provider.</p> | <p>15 Train impacted clinical and administrative staff on the AUC program and how your organization will best meet the requirements.</p> |
| <p>7 For ordering professionals, develop a workflow process that incorporates an AUC consultation code on advanced imaging orders for your applicable Medicare patients.</p> | <p>16 Conduct internal audits of your ordering professionals. Ascertain, by physician, what percentage of orders are deemed by the CDSM as “inappropriate,” determine if there are discernable patterns in terms of the types of medical conditions or tests that are deemed inappropriate and educate your physicians on the results.</p> |
| <p>8 For ordering professionals, designate a 30, 60, or 90-day (or longer) period during 2020 to test your: (i) EHR-enabled CDSM; (ii) ability to use the web-based free CDSM as a contingency in case your system is down; (iii) ability to include the AUC consultation code on the advanced imaging order; (iv) workflow process to accommodate calls from Radiology offices regarding missing or inappropriate AUC codes.</p> | <p>17 Determine if any of your commercial health plans will be leveraging AUC consultation as part of their business policy. For example, ask your plans if consultation of a CMS-qualified CDSM (with an “appropriate” response) can serve as a substitution for conducting a prior authorization.</p> |
| <p>9 For ordering professionals, seek to identify the AUC consultation code that reflects an appropriate test to minimize the chance that CMS will designate them as an outlier and subject them to prior authorization requirements.</p> | <p>18 Continue to monitor MGMA member communications for any changes or updates to the AUC program.</p> |

ADDITIONAL RESOURCES

Additional information regarding the AUC program is available from CMS at <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/AppropriateUse-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>

CMS AUC regulations at **42 CFR 414.94**

The **CY 2016 Physician Fee Schedule (PFS) Final Rule with Comment Period** introduced this program (pages 71102-71116 and pages 71380-71382)

Additional policies related to this program are included in the **CY 2017 PFS Final Rule** (pages 80403-80428 and pages 80554-80555)

The **CY 2018 PFS Final Rule** includes requirements for consulting and reporting under the Medicare AUC program (pages 53187-53201 and page 53363)

Further updates to the AUC program are included in the **CY 2019 PFS Final Rule** (pages 59688-59701 and page 60074)

Questions to CMS regarding the AUC program may be submitted to the CMS Imaging AUC resource box: ImagingAUC@cms.hhs.gov