Good morning,

Due to work commitments, unfortunately, I won't be at the MRCA Conference; enjoy, network, and learn from one another!!

We spent quite a bit of time at the August National Uniform Billing Cmte (NUBC) meeting discussing the upcoming Appropriate Use Criteria (AUC) program, which starts 1-1-20. I have spoken about this quite a bit (in the past) with MRCA & the "update" I sent MRCA members is still relevant.

This effects all outpatient high-cost imaging services; almost 300 services (the CPT/HCPCS list is on pages 6 & 7 in the attachment).

- This affects both hospitals and free-standing imaging providers.
- The goal of Medicare's program is to identify physicians & other practitioners who order unnecessary imaging services, but the provider/such as the hospital, who does the imaging service, must add information to the UB.
- The recent attached MLM, dated 7-26-19, lists basic information.
- When we send claims, we must also send a G-code which states *WHICH* CDSM (Clinical Decision Support Mechanism) service the doctor consulted before he or she ordered the test
- The list of CDSM vendors is also listed on the attachment, page 4
- When we send the claim, we must append one of the new modifiers (see page 3) to the imaging CPT/HCPCS.
- 2020 is an "educational" year but I don't think that's very clear in the MLM. So, claims should not reject if the information is not listed, as of 1-1-20.
- I believe that some hospitals (Epic) have a great process & systems aligned to make this seamless. When an employed doctor or a practitioner using their Epic system, & when they want to order an affected imaging service, Epic routes them to consult the CDSM (Clinical Decision Support System) & then sends the required information the hospital needs on the UB with the order.
- ED Patients: To reiterate, this change also affects CTs, MRIs, ordered for patients in the Emergency Department. (That is a lengthy & complex subject & should probably be a separate discussion.)

- We also need to send the "ordering" physician's NPI on the claim. Since there is not a unique data element to list that (it's usually listed at the "attending"), NUBC/NUCC/X-12/CMS are working on an alternate way to express this information. They will be using the K3 data string. It's the same way we communicated the "POA" indicator prior to the implementation of the 5010 data standards, which some of you may recall. (Once the 7010 standards are implemented, we have assigned a unique data element to list this.)
- If you want the "proposed" K3 options, I have it & can share it but it might be overkill in this email.

…..Below is Information Claudia shared at the May 2019 MRCA Meeting:

APPROPRIATE USE CRITERIA (AUC): see Med Learn Matters (MLM #10481, released 3-2-18)

- At the April National Uniform Billing Committee (NUBC) Meeting in April in Baltimore, this additional administrative burden was discussed in depth. CMS plans to release another MLM soon (probably this month) with additional information as to how hospitals should report these high-cost imaging services starting January 1, 2020.

- In a nutshell:
- To ensure that medical necessity is met when patients receive advanced diagnostic imaging, Medicare has created a program called Appropriate Use Criteria or AUC. The program affects CTs, MRIs, PET, and Nuclear Medicine tests and over 150 CPT/HCPCs.
- The program is part of The Protecting Access to Medicare Act (PAMA) of 2014; see Section 218(b). When a physician or other practitioner orders an advanced imaging service for a Medicare beneficiary, he/she will be required to consult a vendor to determine if the service is appropriate. There are dozens of vendors the provider can choose to use, but they must be approved by Medicare. They are called qualified Clinical Decision Support Mechanisms or CDSM. CDSMs are online portals through which practitioners can access the appropriate use criteria as they treat the patient. In other words, the CDSM will tell the provider if the service should be performed (if it meets the AUC criteria).

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- When doctors send patients to a hospital (or to an independent diagnostic testing facility) to receive the CT, MRI, PET, or Nuclear Medicine test, they must give the hospital/free-standing center the information/results from the CDSM. That information must also be listed and sent on the UB-04 or 1500 claim (if applicable).

- Affects UB-04 and 1500 claims when billing for outpatient CTs, MRIs, PET, & Nuclear Medicine services (150 CPT/HCPCS).
- Ordering Doctor will get the appropriate g-code and modifier from the CDSM (clinical decision support mechanism) and sends it to the provider who is doing the service
    - If doctor is too busy, the federal registrar clarifies that "nurse practitioner" or other staff can also access CDSM

- A number of doctors and hospitals have voluntarily been participating in the program since July, 2018. When hospitals send claims, they are listing modifier QQ on the claim which tells CMS that the ordering doctor consulted a CDSM. The program is complicated since hospitals must rely on the physician or practitioner to obtain the AUC data and send that information with the order.

- Which Payers is this applicable to?
    - This affects patients who have Medicare FFS (original Medicare).
    - It does not affect patients who have a Medicare Advantage plan (the HMOs, such as Medicare Plus Blue).
    - I have heard verbally that this regulation does not apply to CAHs; I have not checked

- Hospitals may do voluntary reporting now, but process will change 1-1-20
- Applicable settings have been expanded to include independent diagnostic testing facilities and the ED.

AUC Reporting Changes 1-1-2020

- The new regulations and changes to how we report AUC will change, effective 1-1-2020
- When hospital registers the patient, it still needs to check LCD & NCDs. If doesn't meet medical necessity criteria, then the hospital must follow ABN process.
- CMS said at the meeting (but this may change) that the new reporting, effective 1-1-20, includes eight new modifiers; examples: MF MG MA-suspected emergency or emergency. Another modifier indicates that there is a hardship exemption, such as a tornado, hurricane, or the physician does not have access to the internet…
    - We should add modifier to CPT code for the procedure
    - Look for the upcoming information in a new Med Learn Matters; all this is subject to change.

AUC-The Goal of the Program:

- Identify ordering doctors who are outliers, who order services that are not Medically Necessary.

AUC- MORE ISSUES:

- Ordering Doctor's NPI is usually the attending Provider.
- But there is not a way to report this on the UB. The Ordering Provider is a requirement of the program. This was discussed at the NUBC and voted on. As a workaround, use the K3 segment
    - Some of you may recall that this is the same segment we had used for the Present on Admission (PoA) indicator, prior to 5010 implementation.
    - TR3 notes, use 2420D at line level

AUC-ED Patients:

- AUC is also applicable for patients seen in the ED.
- Question raised at the NUBC: If a patient is seen in the ED, can we assume it's okay to use the new proposed MA modifier (suspected emergency). It would be difficult to consult a CDSM for ED patients.
    - We do not currently have answers.

I suggest we familiarize ourselves and our teams with AUC Acronyms & Terms:

- ACI-advancing care information
- AUC-appropriate use criteria
- CAH-critical access hospital
- CDSM-clinical decision support mechanism
- EPs-eligible professionals
- IDTF-independent diagnostic testing facilities
- PLE-provider-led entities
- MIPS-merit-based incentive payment system
- NPI-national provider identifier
- UCI-unique consultation identifier
- Outlier (physicians)-doctors who are not following the criteria

People can call or email Claudia if you have questions. She is usually available between 6-7 am & after 7pm while she is driving.

Claudia's Cell 810 394 2777