REVENUE CYCLE CODING STRATEGIES



Is Your Organization Ready for AUC Implementation?

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Agenda

- AUC/CDS Background
- Current Knowns and Unknowns/Questions
- Approaching the Challenge – Bridging the Gap
- Next Steps



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Appropriate Use Criteria

Introduced in PAMA

Utilization of Appropriate Use Criteria (AUC) for advanced diagnostic studies

- CT
- MR
- Nuclear Medicine – including PET

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Appropriate Use Criteria

CMS can only approve the AUC that are developed or endorsed by provider-led entities (PLEs).

- Must be evidence based
- Listing is on CMS's website

Once a PLE is "qualified" all of the AUC developed or endorsed by that PLE are considered to be "specified AUC" for the purposes of the requirements.

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Appropriate Use Criteria

8 Priority Clinical Areas

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- Low back pain
- Cervical or neck pain
- Shoulder pain (to include suspected rotator cuff)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)

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Qualified PLEs as of June 2019

American College of Cardiology Foundation
American College of Radiology
Banner University Medical Group-Tucson University of Arizona
CDI Quality Institute
Cedars-Sinai Health System
High Value Practice Academic Alliance
Intermountain Healthcare
Johns Hopkins University School of Medicine*
Massachusetts General Hospital, Department of Radiology
Medical Guidelines Institute
Memorial Sloan Kettering Cancer Center
National Comprehensive Cancer Network
Sage Evidence-based Medicine & Practice Institute
Society for Nuclear Medicine and Molecular Imaging
Synergetic Professional Guidelines Institute*
University of California Medical Campuses
University of Pennsylvania Health System
University of Texas MD Anderson Cancer Center
University of Utah Health
University of Washington School of Medicine
Virginia Mason Medical Center
Weill Cornell Medicine Physicians Organization

*** Indicates newly qualified PLEs as of June 30, 2019**

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/PLE

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Appropriate Use Criteria

- Ordering physician must access AUC through a Clinical Decision Support Mechanism (CDSM)
- CDSM is an electronic portal
  - –Module in an EHR
  - –Web-based system
- CDSM will pull information about the patient from the EHR and/or the ordering physician will enter the information and immediate feedback will be provided re: appropriateness of exam

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Mechanisms

Mechanism Name	Code
eviCore healthcare's Clinical Decision Support Mechanism	G1001
MedCurrent OrderWise™	G1002
Medicalis Clinical Decision Support Mechanism	G1003
National Decision Support Company CareSelect™*	G1004
National Imaging Associates RadMD	G1005
Test Appropriate CDSM*	G1006
AIM Specialty Health ProviderPortal®*	G1007
Cranberry Peak ezCDS	G1008
Sage Health Management Solutions Inc. RadWise®	G1009
Stanson Health's Stanson CDS	G1010
AgileMD's Clinical Decision Support Mechanism	G1011
EvidenceCare's Imaging Advisor	G1011
InveniQA's Semantic Answers in Medicine™	G1011
Reliant Medical Group CDSM	G1011
Speed of Care CDSM	G1011
HealthHelp's Clinical Decision Support Mechanism	G1011
INFINX CDSM	G1011
LogicNets AUC Solution*	G1011

*Free Tool Available

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/CDSM

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Appropriate Use Criteria

Requirement is that AUC must be consulted

Radiologists will not be exempt

Does not apply to inpatient, certain emergency studies or to ordering physicians who qualify for a hardship exception

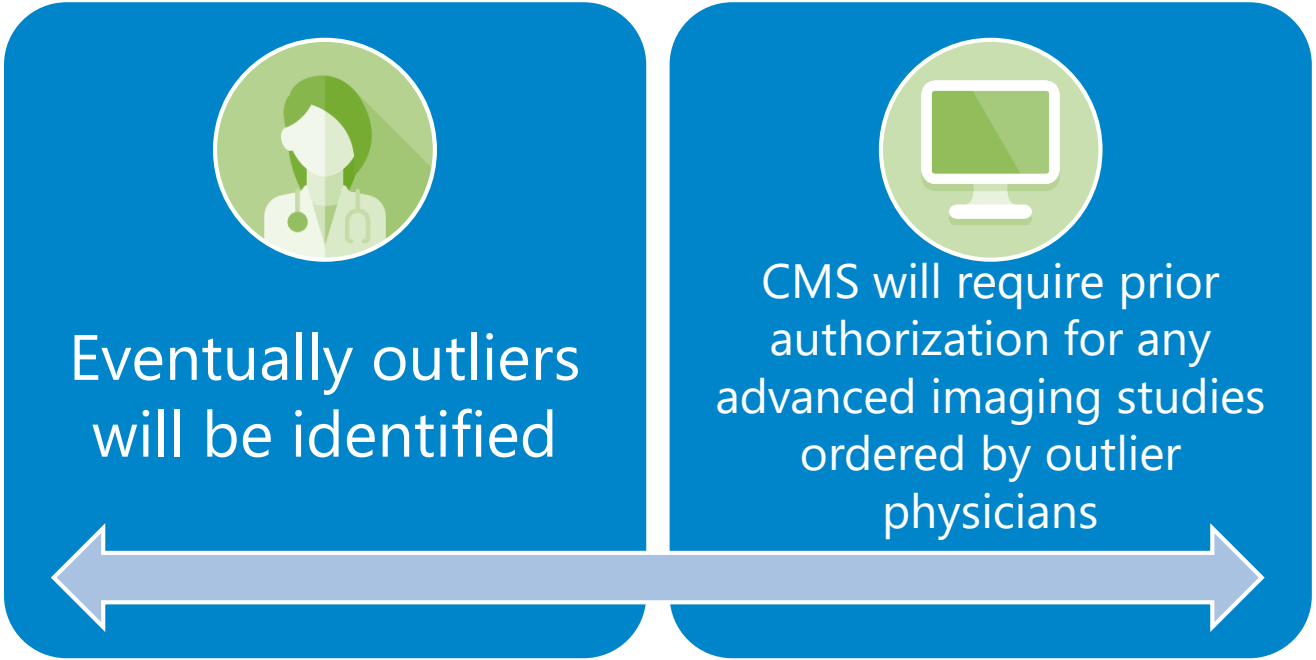
- There are no hardships for furnishing professionals
- CAHs are exempt

Ordering professionals must communicate the results of the consultation to the imaging provider

- Facility & Radiologist

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Appropriate Use Criteria



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Implementation Timeline

Original implementation was January 1, 2017

CDS delayed in 2016-2018 Final Rules

New implementation date of January 1, 2020 – testing period of 1 year

- Mandatory implementation date of 1/1/21

Voluntary reporting period of 7/2018 – 12/2019

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Implementation

2020 is a testing year

Medicare will pay regardless of whether or not AUC recommends the study

Beginning January 1, 2021 payment will be denied if the furnishing professionals' claims lack the required AUC information

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New Reporting Requirements

Required beginning 1/1/2020

- 1 G-code required on the claim per mechanism
- Modifiers to be assigned at the CPT code level indicating adherence to the utilized AUC
  - Adhered, Not Adhered, Not applicable

Many operational concerns with these requirements

- Facility – how to add modifiers
- Radiologists – how to get the information

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Modifiers

Table 1 HCPCS Modifiers for AUC Program

	HCPCS MODIFIER	DESCRIPTION
Emergent	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
Hardship	MB	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access
Hardship	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
Hardship	MD	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances
G Code Req'd	ME	The order for this service adheres to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
G Code Req'd	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
G Code Req'd	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

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G-Codes

Table 2 G-codes for AUC Program

G-Codes	DESCRIPTION
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

CMS has also provided the full list of HCPCS advanced imaging procedure codes which are include in the AUC program.

This can be reviewed in the MLN Matters-MM11268, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf.

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What Do We Know?

Effective 1/1/20 Radiologists can start reporting a G code at the claim level and a modifier at the line item level for designated exams

- Multiple G codes may be on the same claim

Facilities cannot perform this for the referring physicians

- Referring physicians can have their own clinical staff perform at their direction

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New CMS MLN Matters # SE20002

Issued 1/9/2020

- https://www.cms.gov/files/document/se20002.pdf
- Guidance for OPPS facilities submitting on UB04/CMS1450
  - Required reporting of G-Codes and Modifiers
  - Reporting of ordering provider's NPI

Covered Several Scenarios

- Qualified CDSM specific HCPCS not yet available
- Multiple consultations of the same CDSM

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Example 1: An Emergency Room Claim – CT is being rendered to a patient with a suspected or confirmed emergency medical condition, for the MRI there is no suspected or confirmed emergency medical condition.

3a PAT. CNTL #	4 TYPE OF BILL
b. MED. REC.#	0131
5. FED.TAX NO.	6. STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020

CT Ordering professional is not required to consult a clinical decision support mechanism for CT.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES
1	0352	DK9876543210	74261 MA	010120	1	1000 .00	
2	0450	EMERG ROOM	99285	010120	1	2000 .00	
3	0612	DK0123456789	72148 ME	010120	1	1500 .00	
4	0612	MRI/SPINE	G10xx	010120	1	.01	

CDSM consulted for MRI and order adheres to the criteria.

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Example 2: An Outpatient Hospital Claim hardship – Ordering Professional had insufficient Internet

3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC #		0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH
	01012020	01012020

8 PATIENT NAME		9 PATIENT ADDRESS	
a		a	
b		b	

10 BIRTHDATE	11 SEX	ADMISSION 13 HR	14 TYPE	15 SRC	12 DATE	16 D HR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29. ACDT STATE	30.

31 OCCURENCE CODE	DATE	32 OCCURENCE CODE	DATE	33 OCCURENCE CODE	DATE	34 OCCURENCE CODE	DATE	35 CCURRENCE SPAN CODE	FROM	THROUGH	36 CCURRENCE SPAN CODE	FROM	THROUGH	37

38

Hardship Modifier – Ordering Professional had insufficient Internet.

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0352	DK9876543210	74261 MB	010120	1	1000 .00		
2								
3								
4								
5								
6								
7								
8								
9								

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Example 3: An Outpatient Hospital Claim hardship – EHR or CDSM vendor Issues

3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC #		0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH
	01012020	01012020

8 PATIENT NAME | 9 PATIENT ADDRESS | 10 BIRTHDATE | 11 SEX | ADMISSION 13 HR 14 TYPE 15 SRC | 16 D HR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29. ACDT STATE | 30

31 OCCURENCE CODE DATE | 32 OCCURENCE CODE DATE | 33 OCCURENCE CODE DATE | 34 OCCURENCE CODE DATE | 35. CCURRENCE SPAN CODE FROM THROUGH | 36. CCURRENCE SPAN CODE FROM THROUGH | 37

38

Hardship Modifier – EHR or CDSM vendor Issues.

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0352	DK9876543210	74261 MC	010120	1	1000 .00		
2								
3								
4								
5								
6								
7								
8								
9								
10								

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Example 4: An Outpatient Hospital Claimhardship – Ordering Physician in significant hardship exception of extreme and uncontrollable circumstances

1	3a PAT. CNTL #		4 TYPE OF BILL
	b. MED. REC.#		0131
	5. FED.TAX NO.	6. STATEMENT COVERS PERIOD FROM / THROUGH	7
		01012020 / 01012020	

8 PATIENT NAME		9 PATIENT ADDRESS				
a		a				
b		b		c	d	e

10 BIRTHDATE	11 SEX	ADMISSION 13 HR	14 TYPE	15 SRC	12 DATE	16 D HR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29. ACDT STATE	30.

31 OCCURENCE CODE	DATE	32 OCCURENCE CODE	DATE	33 OCCURENCE CODE	DATE	34 OCCURENCE CODE	DATE	35. CCURRENCE SPAN CODE	FROM	THROUGH	36. CCURRENCE SPAN CODE	FROM	THROUGH	37

Hardship Modifier – Ordering Physician in significant hardship exception. If hospital was in disaster area, append Condition Code DR to the hospital claim.

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS CODE		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES		48 NON-COVERED CHARGES	49	
1	0352	DK9876543210	74261	MD	010120	1	1000	.00			1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12

Example 5: An Outpatient Hospital Claim– Unknown, CDSM not provided with order

3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC #		0131
5. FED TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH
	01012020	01012020

8 PATIENT NAME | 9 PATIENT ADDRESS | 10 BIRTHDATE | 11 SEX | 12 DATE | 13 HR | 14 TYPE | 15 SRC | 16 D HR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29. ACDT STATE | 30.

31 OCCURENCE CODE DATE | 32 OCCURENCE CODE DATE | 33 OCCURENCE CODE DATE | 34 OCCURENCE CODE DATE | 35. CCURRENCE SPAN CODE FROM THROUGH | 36. CCURRENCE SPAN CODE FROM THROUGH | 37

38

Uknown Modifier – CDSM not provided with order

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	0352	DK9876543210	74261 MH	010120	1	1000 .00		
2								
3								
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5								
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8								
9								
10								
11								
12								
13								

Example 6: An Outpatient Hospital Claim– CDSM consulted and order adheres

3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC #		0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM / THROUGH	7
	01012020 / 01012020	

8 PATIENT NAME	9 PATIENT ADDRESS	10 BIRTHDATE	11 SEX	ADMISSION 13 HR / 14 TYPE / 15 SRC	12 DATE	16 DHR	17 STAT	CONDITION CODES 18–28	29. ACDT STATE	30.

31 OCCURENCE CODE / DATE	32 OCCURENCE CODE / DATE	33 OCCURENCE CODE / DATE	34 OCCURENCE CODE / DATE	35. CCURRENCE SPAN CODE / FROM / THROUGH	36. CCURRENCE SPAN CODE / FROM / THROUGH	37

38

CDSM Adherence Modifier – CDSM consulted and order adheres

	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a			
b			
c			
d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0352	DK9876543210	74261 ME	010120	1	1000 .00			1
2	0359	CT SCAN/OTHER	G10xx	010120	1	.01			2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11

Example 7: An Outpatient Hospital Claim– CDSM consulted and order does not adhere

3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC.#		0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH
	01012020	01012020

8 PATIENT NAME a b | 9 PATIENT ADDRESS a b c d e

10 BIRTHDATE | 11 SEX | ADMISSION 13 HR 14 TYPE 15 SRC | 12 DATE | 16 D HR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29. ACDT STATE | 30.

31 OCCURENCE CODE DATE | 32 OCCURENCE CODE DATE | 33 OCCURENCE CODE DATE | 34 OCCURENCE CODE DATE | 35. CCURRENCE SPAN CODE FROM THROUGH | 36. CCURRENCE SPAN CODE FROM THROUGH | 37

38

CDSM Non-Adherence Modifier – CDSM consulted and order does not adhere

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0352	DK9876543210	74261 MF	010120	1	1000.00			1
2	0359	CT SCAN/OTHER	G10xx	010120	1	.01			2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11

Example 8: An Outpatient Hospital Claim– CDSM consulted but no AUC for service

3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC.#		0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 13 HR	14 TYPE	15 SRC	12 DATE	16 D HR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29. ACDT STATE	30.

31 OCCURENCE CODE	DATE	32 OCCURENCE CODE	DATE	33 OCCURENCE CODE	DATE	34 OCCURENCE CODE	DATE	35. CCURRENCE SPAN CODE	FROM	THROUGH	36. CCURRENCE SPAN CODE	FROM	THROUGH	37

38

CDSM No AUC for service Modifier – CDSM consulted but no AUC for service

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0352	DK9876543210	74261 MG	010120	1	1000 .00			1
2	0359	CT SCAN/OTHER	G10xx	010120	1	.01			2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12

Example 9: An Outpatient Hospital Claim– Multiple services ordered same Ordering Provider, Same CDSM tool

3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC #		0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM	THROUGH
	01012020	01012020

8 PATIENT NAME | 9 PATIENT ADDRESS | 10 BIRTHDATE | 11 SEX | ADMISSION 13 HR | 14 TYPE | 15 SRC | 12 DATE | 16 D HR | 17 STAT | CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28 | 29. ACDT STATE | 30.

31 OCCURENCE CODE DATE | 32 OCCURENCE CODE DATE | 33 OCCURENCE CODE DATE | 34 OCCURENCE CODE DATE | 35. CCURRENCE SPAN CODE FROM THROUGH | 36. CCURRENCE SPAN CODE FROM THROUGH | 37

38

CDSM Modifier – Multiple services ordered same Ordering Provider, Same CDSM

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0351	DK9876543210	70450 ME	010120	1	1000 .00			1
2	0352	DK9876543210	74261 ME	010120	1	1000 .00			2
3	0359	CT SCAN/OTHER	G10xx	010120	2	.02			3
4									4
5									5
6									6
7									7
8									8
9									9
10									10

Example 10: An Outpatient Hospital Claim– Multiple services ordered same Ordering Provider, different CDSM

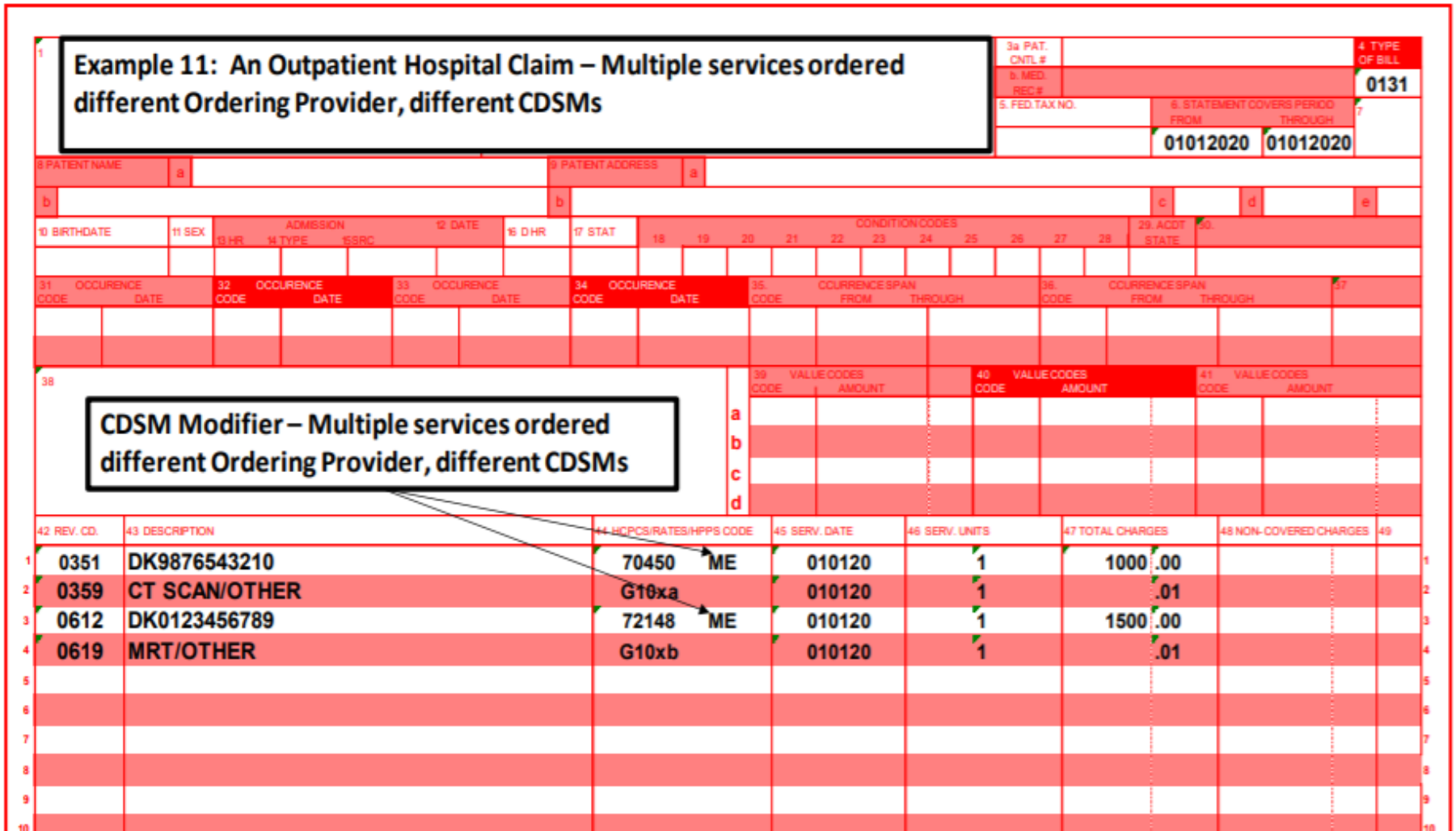
3a PAT. CNTL #		4 TYPE OF BILL
b. MED. REC.#		0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020	7

8 PATIENT NAME	9 PATIENT ADDRESS
10 BIRTHDATE	11 SEX
ADMISSION 13 HR	14 TYPE
15 SRC	16 D HR
17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE	30
31 OCCURENCE CODE DATE	32 OCCURENCE CODE DATE
33 OCCURENCE CODE DATE	34 OCCURENCE CODE DATE
35. CCURRENCE SPAN CODE FROM THROUGH	36. CCURRENCE SPAN CODE FROM THROUGH
37	38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
a						
b						
c						
d						

CDSM Modifier – Multiple services ordered same Ordering Provider, different CDSM.

	42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0351	DK9876543210	70450 ME	010120	1	1000 .00			1
2	0359	CT SCAN/OTHER	G10xb	010120	1	.01			2
3	0612	DK9876543210	72148 ME	010120	1	1500 .00			3
4	0619	MRT/OTHER	G10xa	010120	1	.01			4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13


Example 11: An Outpatient Hospital Claim – Multiple services ordered different Ordering Provider, different CDSMs
3a PAT. CNTL #
b. MED. REC #
4 TYPE OF BILL
0131
5. FED.TAX NO.
6. STATEMENT COVERS PERIOD FROM THROUGH
01012020
01012020
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
ADMISSION 13 HR 14 TYPE 15 SRC
12 DATE
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29. ACDT STATE
30.
31 OCCURENCE CODE DATE
32 OCCURENCE CODE DATE
33 OCCURENCE CODE DATE
34 OCCURENCE CODE DATE
35 COURRENCE SPAN CODE FROM THROUGH
36 COURRENCE SPAN CODE FROM THROUGH
37
38
CDSM Modifier – Multiple services ordered different Ordering Provider, different CDSMs
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d
42 REV. CD.
43 DESCRIPTION
44 HCPCS/RATES/HPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
1 0351 DK9876543210 70450 ME 010120 1 1000 .00
2 0359 CT SCAN/OTHER G10xa 010120 1 .01
3 0612 DK0123456789 72148 ME 010120 1 1500 .00
4 0619 MRT/OTHER G10xb 010120 1 .01

Additional Questions…

- *Will CDS be required when Medicare is the secondary payer?* YES

- *How does the CDS consultation requirement apply to observation patients?* YES

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Additional Questions…

- *How will claims indicate the ordering professional NPI on institutional claims? Information published by CMS*
- *What will happen to modifier MH in 2021? TBD*
- *What modifier should radiologists use if the TC was performed in a non-applicable setting? TBD*

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Additional Questions… eOrdering Coalition

- *How is the Clinical Decision Support (CDS) consultation process affected when the Advanced Diagnostic Imaging Service (ADIS) procedure ordered is changed? "Re" consultation is not required*

- *How should CDS consultation be reported for patients with multiple ADISs reported on the same claim, some of which might have resulted from consultations with different qCDSMs? Addressed in the most recent CMS transmittal*

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Additional Questions… eOrdering Coalition

- *How will rendering providers determine when a claim denial results from a failure to document the CDS consultation as distinct from some other cause?*

- *How should CDS consultation be reported for patients with add-on codes?*

- *How will the CDS consultation requirement apply to ADIS that are not covered by Medicare for which an Advanced Beneficiary Notice (ABN) is required?*

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Now What?

Determine how the flows will change

How will facilities get the information from the referring physician?

How will that information be passed to the Radiologists (billing company)?

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Bridging the Gap







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Key Areas of Concern

ER Patients

- How will you determine when this is required versus “not applicable” from a process standpoint?

Lack of Compliance by Referring Physicians

- How will this be reinforced/addressed by the hospital?

Manual Orders

- How many do you have and what will be the process?

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Steps to Take…

- What is the current facility plan?
  - Already implemented?
  - In process?
  - Not on the radar?!
- Understand the current processes
  - Scheduled outpatient and ED
  - Map them out to ensure everyone is on the same page

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Current Medicare Workflow for ordering Advanced Diagnostic Imaging

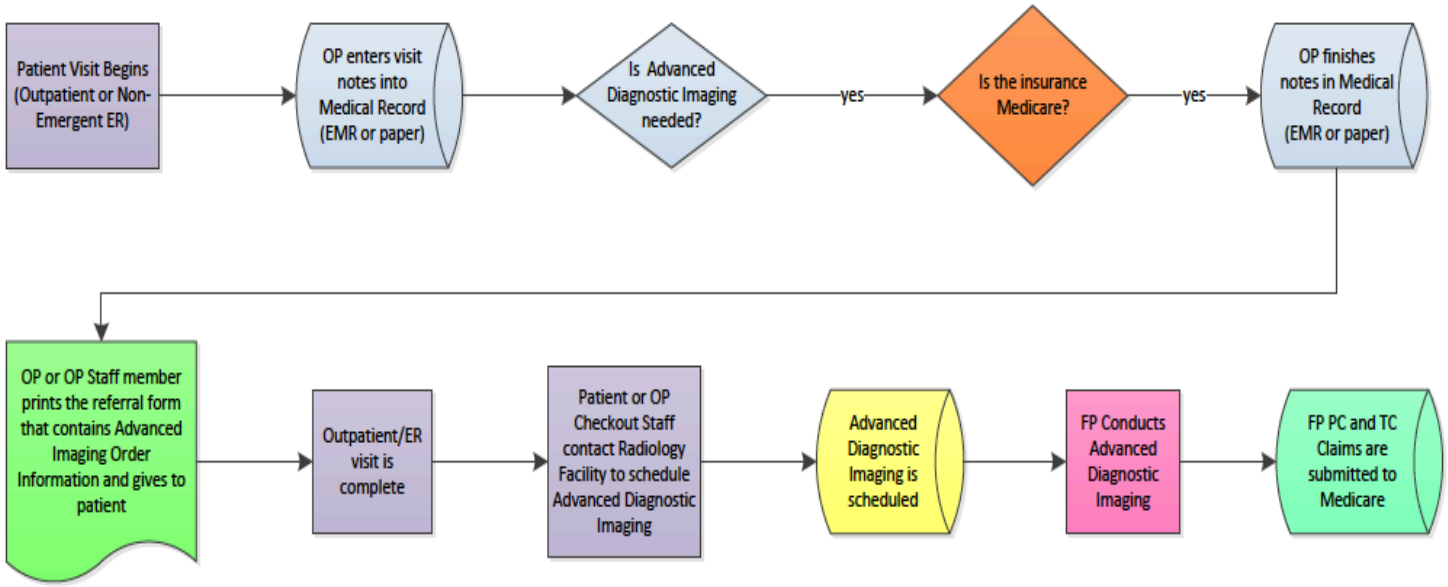
Workflow: Advanced Diagnostic Imaging Service (Medicare FFS, Outpatient non-emergent)
Rev. 9.1.17

Abbreviations:

AUC	Appropriate Use Criteria
CDSM	Clinical Decision Support Mechanism
CMS	Centers for Medicare and Medicaid Services
EMR	Electronic Medical Record
FP	Furnishing Provider
NPI	National Provider Identifier
OP	Ordering Provider

Legend:

- Patient
- Ordering Provider
- OP Staff
- AUC/CDSM system
- FP Radiology Scheduler
- Furnishing Provider
- FP Claims staff
- CMS



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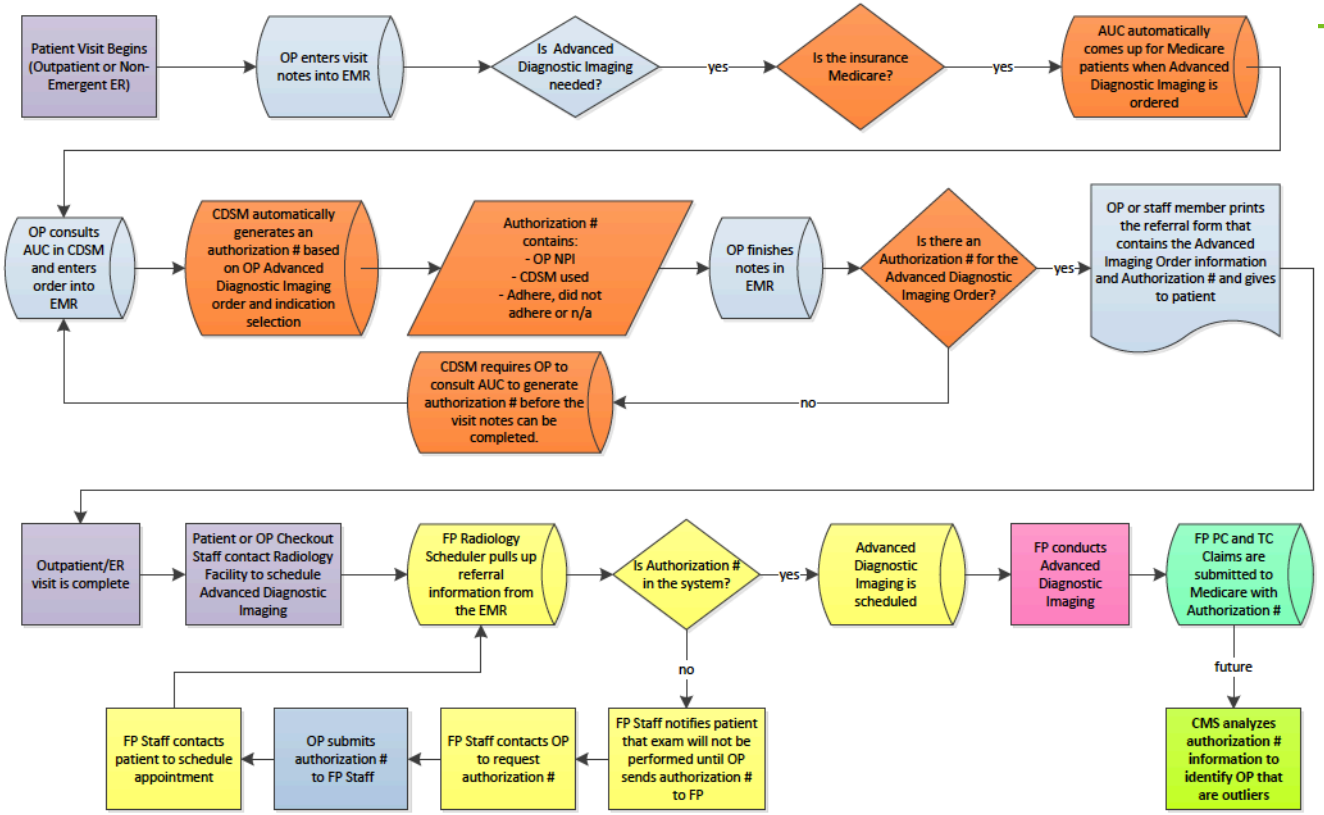
Use Case #1: Ordering Provider and Furnishing Provider use common Electronic Medical Record

Workflow: AUC for Advanced Diagnostic Imaging Service (Medicare FFS, Outpatient Non-emergent)
Rev. 9.1.17

Abbreviations:

AUC	Appropriate Use Criteria
CDSM	Clinical Decision Support Mechanism
CMS	Centers for Medicare and Medicaid Services
EMR	Electronic Medical Record
FP	Furnishing Provider
NPI	National Provider Identifier
OP	Ordering Provider

Legend:
- Patient
- Ordering Provider
- AUC/CDSM system
- FP Staff
- Furnishing Provider
- FP Claims staff
- CMS



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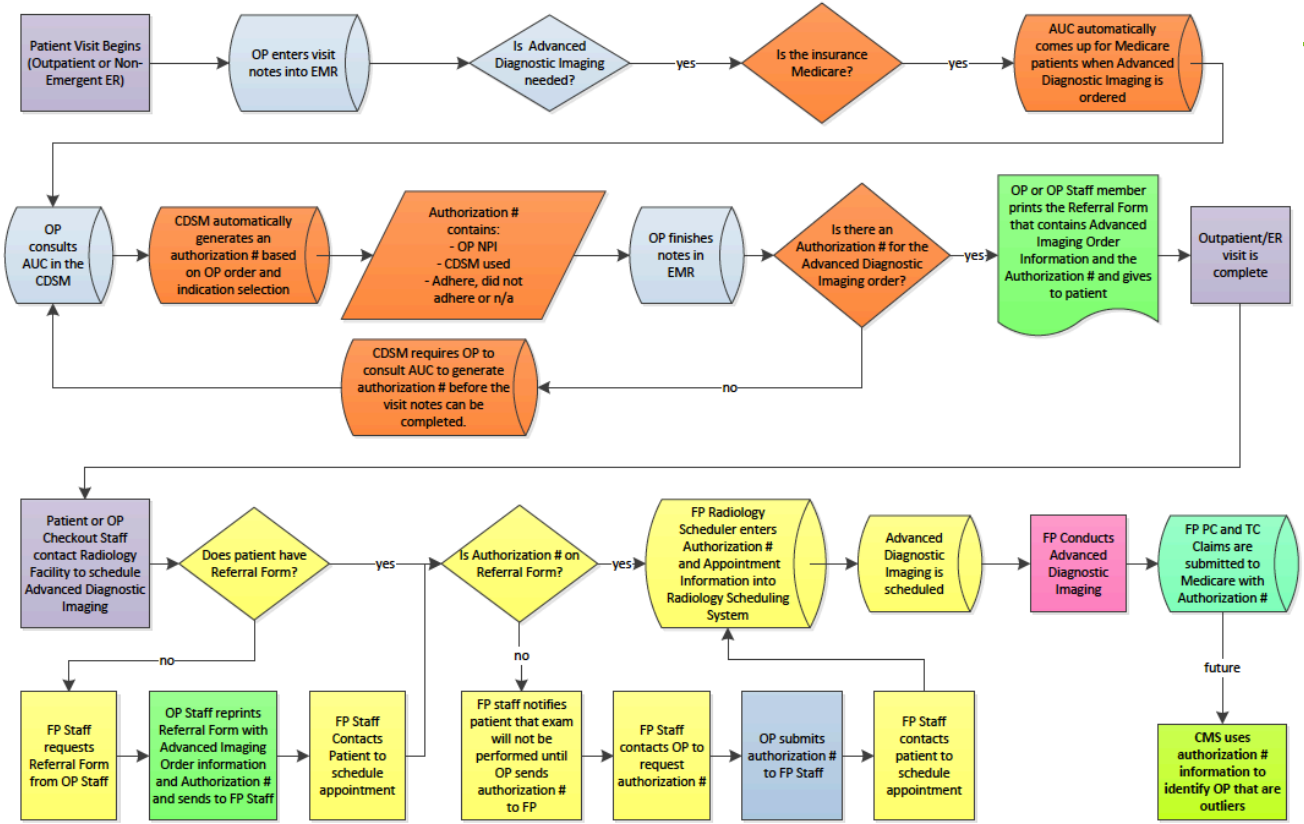
Use Case #2: Ordering Provider and Furnishing Provider use different Electronic Medical Record Systems

Workflow: AUC for Advanced Diagnostic Imaging Service (Medicare FFS, Outpatient non-emergent)
Rev. 9.1.17

Abbreviations:

AUC	Appropriate Use Criteria
CDSM	Clinical Decision Support Mechanism
CMS	Centers for Medicare and Medicaid Services
EMR	Electronic Medical Record
FP	Furnishing Provider
NPI	National Provider Identifier
OP	Ordering Provider

Legend:
- Patient
- Ordering Provider
- OP Staff
- AUC/CDSM system
- FP Staff
- Furnishing Provider
- FP Claims staff
- CMS



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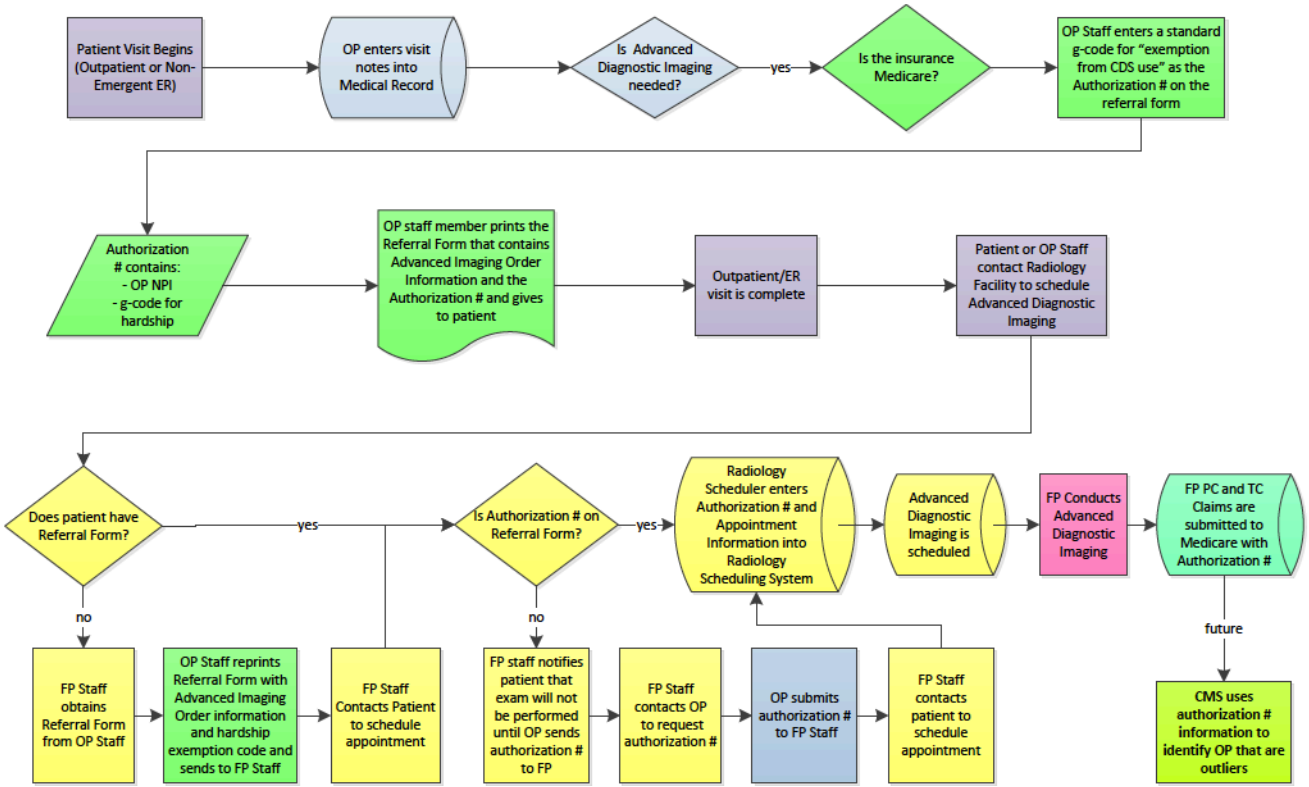
Use Case #3: Ordering Provider opts out due to hardship (hardship has been approved by CMS)

Workflow: AUC for Advanced Diagnostic Imaging Service (Medicare FFS, Outpatient non-emergent)
Rev. 9.1.17

Abbreviations:

AUC	Appropriate Use Criteria
CDS	Clinical Decision Support
CMS	Centers for Medicare and Medicaid Services
FP	Furnishing Provider
NPI	National Provider Identifier
OP	Ordering Provider

Legend:
- Patient
- Ordering Provider
- OP Staff
- FP Staff
- Furnishing Provider
- FP Claims staff
- CMS



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Key Areas of Concern



- Referring physicians
- Who owns educating on this requirement?

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Making Progress

- Have the conversations now – do not wait for the hospitals to reach out
- Ask and expect details now versus later
- Request to be a part of the process to identify areas of concern so they can be addressed before the end of the year
- Hold monthly then weekly meetings as the implementation date gets closer

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Making Progress

- Continue to monitor CMS updates to ensure integration with the process

- Keep a running list of things that must be addressed prior to implementation.

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Next Steps

- Specifically clarify your organization's issues and concerns
- Have a clear plan to address
- Learn from others – good, bad & ugly
- Watch for CMS updates and incorporate into your plans

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AUC Job Aid



Who is the primary sponsor of AUC implementation?	◯ Imaging Dept ◯ IT Dept ◯ Other	
What CDSM(s) has the organization selected?		
Is the CDSM integrated into the facility's EHR?	◯ Yes. ◯ NO.	If yes, where is the CDS feedback stored/displayed? ◯ On the order ◯ In the accession record ◯ Other _____
Has the facility implemented AUC for OP procedures?	◯ Yes. ◯ NO.	If no, what is the anticipated implementation date? _____
Has the facility implemented AUC for ED procedures?	◯ Yes. ◯ NO.	If no, what is the anticipated implementation date? _____ If yes, how does the organization identify ED studies that require AUC? _____ Determined by ED Physician _____ System facilitates ◯ Other _____
For electronic orders how will the AUC data be communicated to the radiologists?		_____ Interface _____ Provided in RIS _____ Provided via separate report ◯ Other _____ _____ TBD
Does the facility accept paper orders?	◯ Yes. ◯ NO.	If yes, Who will be responsible for inputting AUC data from paper orders? _____ Where will the AUC data be placed in the facility system? _____
For paper orders how will the AUC data be communicated to the radiologists?		_____ Interface _____ Provided in RIS _____ Provided via separate report ◯ Other _____ _____ TBD
Who is responsible for educating the ordering providers on AUC/CDSM?		
Does the facility have employed providers ordering imaging?	◯ Yes. ◯ NO.	If yes, will the education plan be different for employed providers versus community providers? ____Yes. ____No. How: _____
Who is responsible for ensuring interfaces are updated to provide the data to the radiologists (and their billing company if applicable)?		_____ Radiology IT _____ Facility IT _____ Radiologists' staff ◯ Other _____ _____ N/A (If N/A why?) _____
Is the facility a Critical Access Hospital (CAH)?	◯ Yes. ◯ NO.	If yes, how will the AUC data be communicated to the radiologists? _____ Interface _____ Provided in RIS _____ Provided via separate report ◯ Other _____ _____ TBD

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Questions?
Comments?

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