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Indiana Rural Health Association

Medicare's Proposed Appropriate Use Criteria (AUC) Program

Objectives

At the end of this presentation, participants will understand:

- What is Appropriate Use Criteria
- Why CMS has created the AUC program
- What is required to comply, sooner and later
- What is a Clinical Decision Support Mechanism
- Which imaging studies will require AUC
- When the requirements to report will begin
- How AUC data will be reported on claims

Appropriate Use Criteria

Premise:

Evidence-based Appropriate Use Criteria for imaging can assist clinicians in selecting the imaging study that is most likely to improve health outcomes for patients based on their individual context.

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Appropriate Use Criteria

The Appropriate Use Criteria Program addresses inappropriate uses of imaging and overuse.

AUC leverages EHR technology to capture two objectives:

- higher quality healthcare and
- cost savings for the Medicare program

How did the Appropriate Use Program start?

- First, the Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009.

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HITECH Act Investment

Through HITECH, **$35 billion taxpayer dollars was paid** in incentives to promote the widespread use of health IT, including Electronic Health Records with Computerized Physician Order Entry (CPOE) functionality.

HITECH Promised…

That national investment in EHRs would deliver:

- Improved clinical outcomes (eg, improved quality, reduced medical errors),
- Improved financial outcomes (eg, cost and operational benefits), and
- Improved societal outcomes (eg, improved ability to conduct research, improved population health)

PAMA Delivers…

- In 2014, Congress passed the Protecting Access to Medicare Act, PAMA.

- Within PAMA, Congress instructed CMS to promote the use of Appropriate Use Criteria.

PAMA Established the AUC Program

Section 1834(q)(1)(B) of the Social Security Act

(b) Promoting Evidence-Based Care.--

(1) In general.--Section 1834 of the Social Security Act (42 U.S.C. 1395m), as amended by subsection (a), is amended by adding at the end the following new subsection:

``(q) Recognizing Appropriate Use Criteria for Certain Imaging Services.--

``(1) Program established.--

``(A) In general.--The Secretary shall establish a program to promote the use of appropriate use criteria (as defined in subparagraph (B)) for applicable imaging services (as defined in subparagraph (C)) furnished in an applicable setting (as defined in subparagraph (D)) by ordering professionals and furnishing professionals (as defined in subparagraphs (E) and (F), respectively).

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PAMA requires CMS To:

- Implement an Appropriate Use Criteria Program for advanced diagnostic imaging
- Report to Congress its experience in requiring appropriate use criteria for imaging services, and
- Whether AUC could be used for other services such as
  - radiation therapy and
  - clinical diagnostic laboratory services.

PAMA Gave Deadlines

Under the PAMA Act, four major components of the AUC program were established:

1. Establishment of AUC (criteria) by November 15, 2015;
2. Mechanisms for consultation (CDSMs) with AUC by April 1, 2016;
3. AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals by January 1, 2017; and
4. Annual identification of outlier ordering professionals for services furnished after January 1, 2017

However, Medicare is behind schedule in developing the program, and therefore implementation has been delayed.

Medicare Delayed…

- CMS acknowledges that their progress to date "substantially lags the statutory requirements,"
- The "delay in the statutory timeline is necessary to maximize the opportunity for public comment and stakeholder engagement, also a statutory requirement, and allows for adequate advance notice to practitioners, beneficiaries, AUC developers and CDSM developers."

Medicare Expects…

"When this program is more fully implemented (expected January 1, 2020), consultation with a qualified CDSM will be required and detailed information regarding the ordering professional's consultation must be appended to the furnishing professional's claim. …"

MLN Matters MM10481 – March 2, 2018

How Will AUC Data Appear on Claims?

- Until January 1, 2020 providers are asked to voluntarily report a modifier indicating that AUC were consulted
- After 1/1/2020, Medicare may implement reporting using additional G-codes, similar to the reporting required for outpatient therapy services today.
- The “G-code” line item would convey which AUC was consulted, and a modifier would indicate whether the order adhered to the criteria consulted.
- The G-code would be a nominal charge, such as $1.00, and will not generate any additional reimbursement.

Example – Facility UB04 Claim

- Voluntary reporting – July 1, 2018 thru December 31, 2019

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE Help	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
1	0351	CT	70450QQ	07012018	1	1000 00
2						
3						

- Possible Format for Mandatory Reporting – sometime after 1/1/2020

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES
1	0351	CT	70450	07012020	1	1000 00
2	0351	AUC	GXXXXXX	07012020	1	00 01
3						

G-code representing which decision support mechanism was consulted

Modifier indicating whether the test adhered to criteria

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What are Appropriate Use Criteria?

"Evidence-based AUC for imaging can assist clinicians in selecting the imaging study that is most likely to improve health outcomes for patients based on their individual context."

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What are Appropriate Use Criteria?

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

CMS.gov
Centers for Medicare & Medicaid Services

Appropriate Use Criteria Program

Section 218(b) of the Protecting Access to Medicare Act of 2014 amended Title XVIII of the Social Security Act to add section 1834(q) directing CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. In section 1834(q)(1)(B) of the Act, AUC are defined as criteria that are evidence-based (to the extent feasible) and assist professionals who order and furnish applicable imaging services to make the most appropriate treatment decisions for a specific clinical condition.

What is a Clinical Decision Support Mechanism?

- Appropriate Use Criteria are embodied in “Clinical Decision Support Mechanisms” (CDSM)
- A CDSM uses EHR technology to provide persons involved in care processes with information to make the most appropriate treatment decision for a patient’s specific clinical condition
- A CDSM will inform a provider whether an advanced diagnostic imaging study is indicated for a given clinical condition
- As Ordering providers consult CDSM’s, inappropriate examinations are expected to decrease, resulting in cost savings and improved outcomes

CMS Definition of CDSM

- An interactive, electronic tool for use by clinicians
- Communicates AUC information to the user
- Assists the user in making the most appropriate treatment decision for a patient's specific clinical condition
- May be a module within certified EHR technology or private sector mechanisms independent from certified EHR technology
- Incorporates relevant patient-specific information into the assessment of the appropriateness of an applicable imaging service

A qualified CDSM Must…

- Generate documentation at the time of order that includes:
  1. *which qualified CDSM was consulted*
  2. *the name and national provider identifier (NPI) of the user that consulted the CDSM*
  3. *And whether the service…*
     - *would adhere to specified applicable AUC*
     - *would not adhere to specified applicable AUC*
     - *or whether the specified applicable AUC consulted was not applicable to the service ordered*

What Will Ordering Professionals Need to Do?

- **Ordering physicians** will be required to consult a qualified "Clinical Decision Support Mechanism" when ordering "advanced" diagnostic imaging services for non-emergency outpatient Medicare beneficiaries.
- The ordering physician must report the AUC information to the "furnishing" provider, both the interpreting radiologist and the facility providing the technical component.

What will Furnishing Providers need to do?

- **Facilities and suppliers** which provide the technical component of an advanced diagnostic imaging service will be required to report the ordering physician's AUC data on outpatient claims to Medicare for advanced diagnostic imaging.
- **Interpreting physicians** (i.e. radiologists, cardiologists) will be required to report the ordering physician's AUC data on professional fee claims submitted to Medicare.

What will Furnishing Providers need to do?

When the program is fully implemented, possibly in 2020, the absence of AUC data on an outpatient claim for the technical component or interpretation of Advanced Diagnostic Imaging may result in denial.

The Ordering Professional

A. Consultation by ordering professional.

…an ordering professional shall—

(i) **consult with a qualified decision support mechanism**; and

(ii) **provide to the furnishing professional the information** regarding which CDSM was consulted and whether the order complied.

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The Furnishing Provider

B) **The furnishing professional will report on its claim to Medicare:**

(i) **which qualified clinical decision support mechanism was consulted** by the ordering professional for the service.

(ii) And whether

a) The service **adheres** to appropriate use criteria

b) The service **does not adhere** to such criteria; or

c) Or such criteria was **not applicable** to the service.

(iii) The **NPI of the ordering professional**

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Interdependence & Teamwork

- Furnishing providers rely on the ordering provider for the information necessary to get claims paid
- Ordering providers rely upon furnishing providers to report accurately their use of AUC
- An inaccurate representation of the ordering provider's use of AUC can cause trouble for the ordering professional
- Failure to use AUC can cause denials for the furnishing provider(s)

Once Implemented in 2020(?)

Ordering Physicians must consult AUC for:

- Advanced Diagnostic Imaging
- Ordered for 8 priority clinical areas
- In an “applicable setting” (i.e. paid under applicable payment system)

Which Imaging Services are applicable?

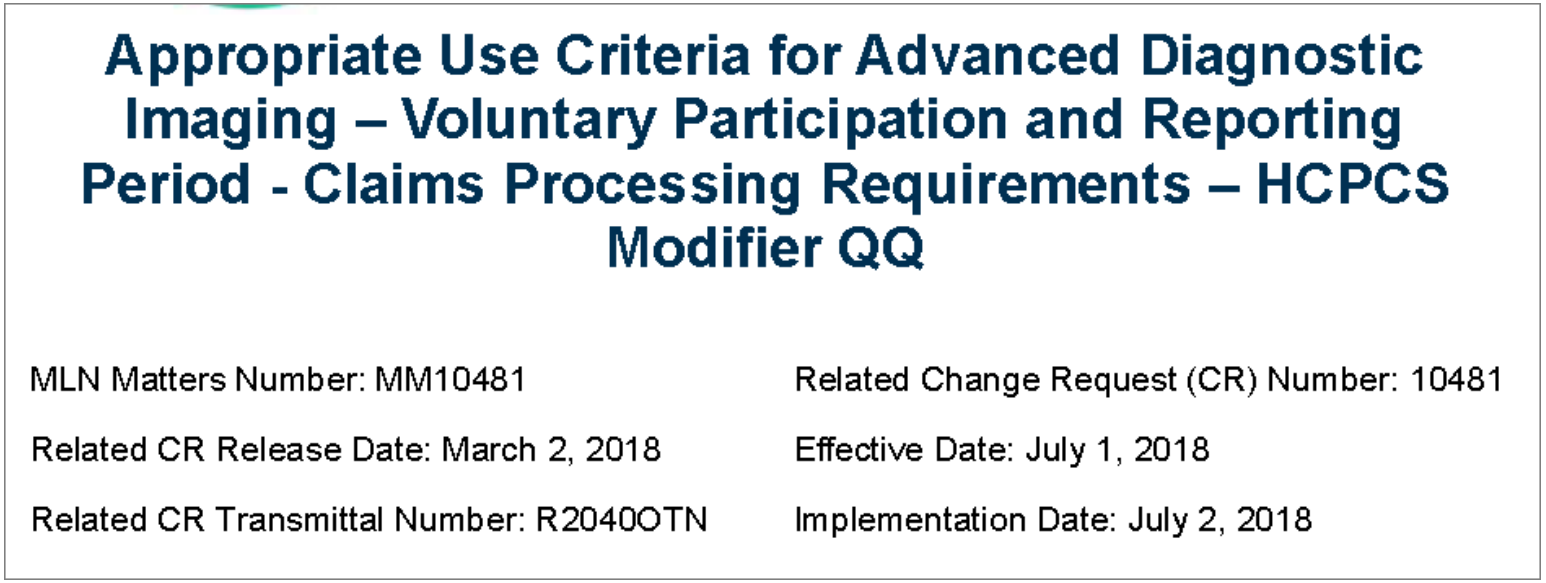
- Magnetic Resonance Imaging (MRI)
- Computed Tomography (CT)
- Positron emission tomography (PET)
- Other diagnostic imaging services as specified by CMS

- *Excludes x-ray, ultrasound, and fluoroscopy.*

Is there a list of HCPCS for applicable Imaging?

A complete list of the HCPCS for which AUC will be required is available at:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10481.pdf



Appropriate Use Criteria for Advanced Diagnostic Imaging – Voluntary Participation and Reporting Period - Claims Processing Requirements – HCPCS Modifier QQ

MLN Matters Number: MM10481

Related Change Request (CR) Number: 10481

Related CR Release Date: March 2, 2018

Effective Date: July 1, 2018

Related CR Transmittal Number: R2040OTN

Implementation Date: July 2, 2018

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What are the 8 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

Priority Clinical Areas

- The list of priority clinical areas represents about 40 percent of advanced diagnostic imaging services paid for by Medicare in 2014
- The first list of priority clinical areas is not the last list
- Additional “Priority Clinical Areas” may be added in future years

What are the Applicable Settings?

Applicable settings include locations at which payment is made under the “applicable payment system” – such as

- physician offices
- hospital outpatient departments and
- ambulatory surgical centers

Applicable Payment System

"Applicable payment system" means:

- The Medicare physician fee schedule (MPFS)
- The Hospital Outpatient Prospective Payment System (OPPS)
- The ambulatory surgical center payment systems (OPPS/ASC)

But not Critical Access Hospitals

The 2018 MPFS Final Rule provides that:

- Any advanced imaging service furnished within a CAH would **not** be furnished in an applicable setting.
- CAH patients who are furnished an advanced diagnostic imaging service in an applicable setting but the claim for that imaging service is not paid under one of the applicable payment systems would **not** require consultation and reporting of the AUC consultation.
- *"This may apply in situations when a CAH has elected Method II billing."*

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When will AUC be required?

CMS *expects* to require AUC data to be submitted by ordering professionals and reported by furnishing professionals for imaging exams ordered **on or after January 1, 2020.**

In the meantime, CMS has asked for simplified voluntary reporting of Modifier QQ beginning July 1, 2018.

Baby Steps – Modifier QQ

- Modifier QQ -- ORDERING PROFESSIONAL CONSULTED A QUALIFIED CLINICAL DECISION SUPPORT MECHANISM FOR THIS SERVICE AND THE RELATED DATA WAS PROVIDED TO THE FURNISHING PROFESSIONAL
- Append Modifier QQ to the Advanced diagnostic imaging HCPCS, i.e. 70450-QQ
- Voluntary reporting - accepted on claims to Medicare for advanced imaging procedures effective July 1, 2018.

Voluntary Reporting – Modifier QQ

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10481.pdf

Appropriate Use Criteria for Advanced Diagnostic Imaging – Voluntary Participation and Reporting Period - Claims Processing Requirements – HCPCS Modifier QQ

If The Ordering Physician Doesn't Consult AUC

Ordering Physicians who do not use or abide by the Appropriate Use Criteria risk being identified as an "outlier professional" starting in two years after reporting begins.

Outlier = Outlaw?

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If The Ordering Physician Doesn't Consult AUC

- Once identified as an "Outlier professional", all orders for advanced diagnostic imaging will be subject to prior authorization requirements.
- Approximately 5% of all ordering providers will be identified as "outlier professionals" based on 2 years of data.
- Medicare has not yet announced the methodology with which they will identify outlier professionals. Watch the 2019 MPFS proposed and final rule for details.

Who Approves the CDSM's?

- **Qualified Provider-Led Entities (PLEs)** are organizations led by physicians
- Approved by CMS to develop, endorse, or modify AUC
- Software vendors must obtain the approval of CDSM modules from a PLE.

What is a Provider-Led Entity (PLE)?

- 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.

Provider-Led Entities

Qualified Provider Led Entities (PLEs) as of June 2017	
American College of Cardiology Foundation	Memorial Sloan Kettering Cancer Center*
American College of Radiology	National Comprehensive Cancer Network
Banner University Medical Group -Tucson University of Arizona	Sage Evidence-based Medicine & Practice Institute*
CDI Quality Institute	Society for Nuclear Medicine and Molecular Imaging
Cedars-Sinai Health System	University of California Medical Campuses
Intermountain Healthcare	University of Utah Health*
Massachusetts General Hospital, Department of Radiology	University of Washington School of Medicine
	Virginia Mason Medical Center*
Medical Guidelines Institute*	Weill Cornell Medicine Physicians Organization

Qualified CDSM's

As of March, 2018, 11 CDSM's were fully qualified:

- AIM Specialty Health ProviderPortal®*
- Applied Pathways CURION™ Platform
- Cranberry Peak ezCDS
- eviCore healthcare's Clinical Decision Support Mechanism
- MedCurrent OrderWiseTM
- Medicalis Clinical Decision Support Mechanism
- National Decision Support Company CareSelect™*
- National Imaging Associates RadMD
- Sage Health Management Solutions Inc. RadWise®
- Stanson Health's Stanson CDS
- Test Appropriate CDSM*

Qualified CDSM's

An additional 5 CDSM's had been granted preliminary qualification as of March 2018:

- Cerner CDS mechanism
- Evinance Decision Support
- Flying Aces Speed of Care Decision Support
- LogicNets' Decision Engines
- Reliant Medical Group CDSM

How Many CDSMs Will There Be?

- There is no limit to the number of CDSM's that may be created;
- CMS will approve new CDSM's on an ongoing basis
- CMS planned to assign each CDSM a unique HCPCS G-code for the purpose of AUC reporting on the claims of furnishing/interpreting providers

Will EHR Workflow handle it?

- Various CDSM's ***unrelated*** to Medicare's Advance Diagnostic Testing AUC program are already embedded within the order entry systems of all leading EMR platforms
- For example, drug interactions are brought to attention when orders for meds are placed
- CDSM's for Advanced Diagnostic Imaging CDSMs are more of the same, but with one significant difference…proof of consultation on claims.

What does a CDSM Look Like?

- EPIC Example CDSM – Physician Views AUC

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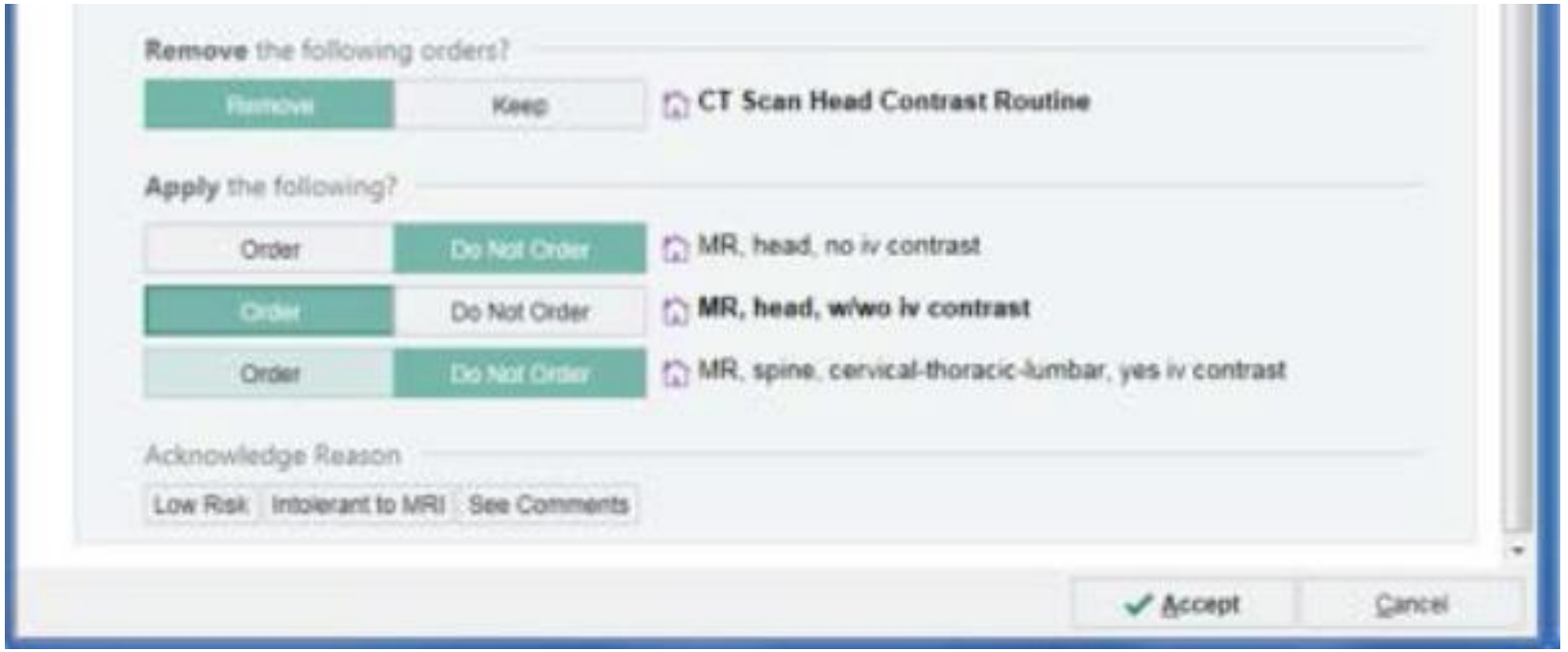
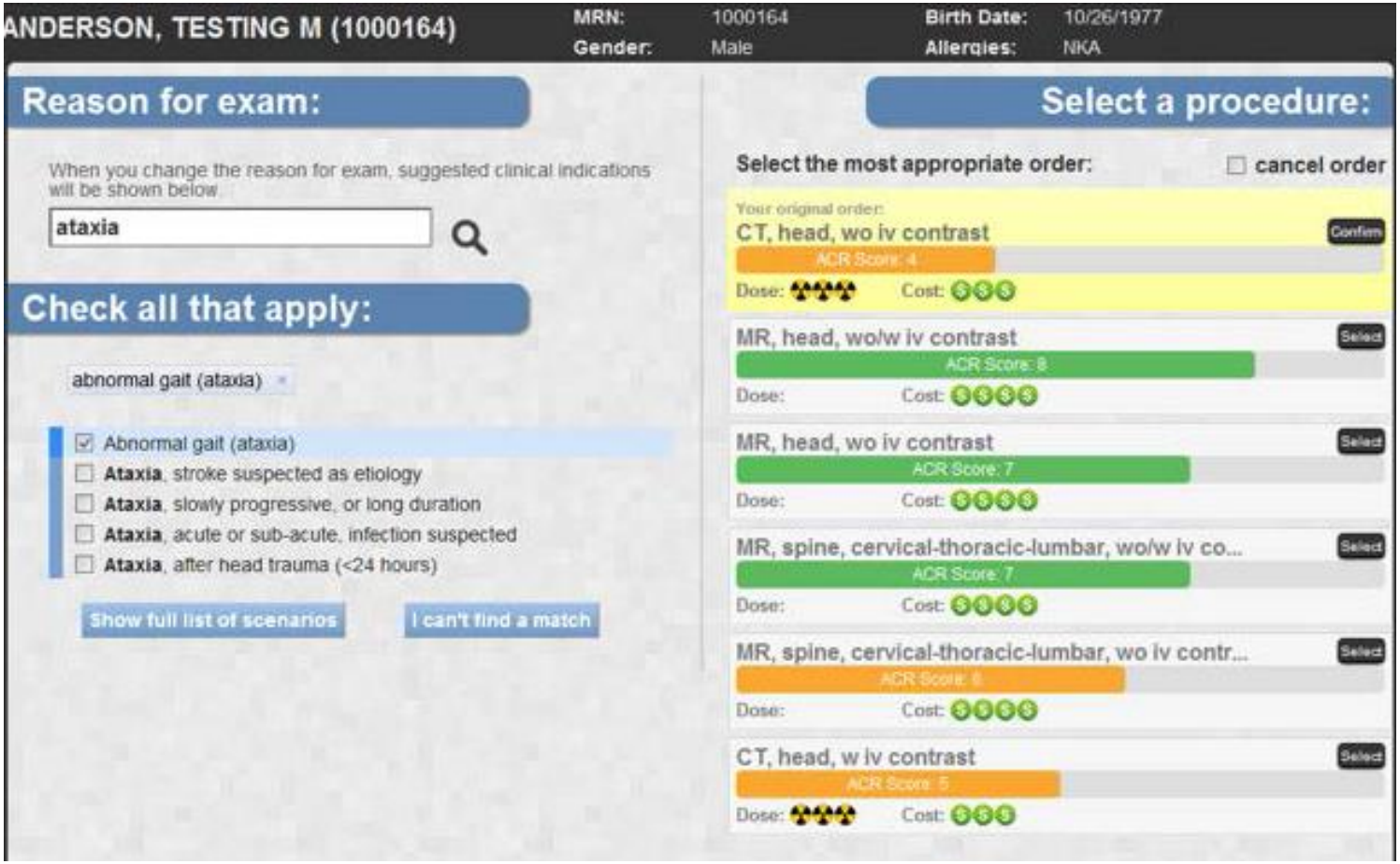
What does a CDSM Look Like?

- EPIC Example CDSM – Physician Places Order



What does a CDSM Look Like?

- Cerner Example CDSM –



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Will the data cross over to claims?

- Ideally, physicians using the Physician Order Entry feature of EHR will be prompted to consult AUC
- The system will record which CDSM was consulted by the ordering provider
- And whether the order for the imaging exam
  - Complied with AUC criteria,
  - Did not comply, or
  - AUC criteria was not applicable to the order

How Will AUC Data Appear on Claims?

- In the 2017 MPFS Proposed Rule, Medicare planned to assign each qualified CDSM an individual HCPCS code.
- The "G-code" line item would convey which AUC was consulted.
- A separate G-code line would be required to correspond with each Advanced Diagnostic Test on the claim.
- The G-code would not generate separate reimbursement (a nominal charge, such as $1.00, may be reported).

How Will AUC Data Appear on Claims?

- Each G-code would have one of 3 modifiers appended to indicate whether the order for the test:
  - adheres to specified applicable AUC
  - does not adhere to specified applicable AUC, or
  - the AUC was not applicable to the service ordered
- AUC G-codes with a modifier would be required on claims for Advanced Diagnostic Imaging, both for facility 837i and the interpreting professional fee 837p

However… claims reporting details are not yet final

MLN Matters MM10481 March 2, 2018:

"The Centers for Medicare and Medical Services (CMS) does not have guidance at this time regarding what the claims-based reporting requirements will be in 2020."

Example – Facility UB04 Claim

- Voluntary reporting – July 1, 2018 thru December 31, 2019

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE (Help)	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	0351	CT	70450QQ	07012018	1	1000 00
2						
3						

- Possible Format for Mandatory Reporting – after 1/1/2020

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES
1	0351	CT	70450	07012020	1	1000 00
2	0351	AUC	GXXXXXX	07012020	1	00 01
3						

G-code representing which decision support mechanism was consulted

Modifier indicating whether the test adhered to criteria

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Are there any exceptions ?

AUC Consulting and reporting requirements are not required for orders under the following circumstances:

1. For emergency services when provided to individuals with emergency medical conditions
2. For an inpatient for which payment is made under Medicare Part A
3. By ordering professionals who are granted a significant hardship exception to the Medicare EHR Incentive Program

Significant Hardship Exceptions

- Proposed but not finalized:
  - Insufficient Internet Connectivity
  - Extreme and Uncontrollable Circumstances (e.g., a hurricane, natural disaster, or public health emergency)
  - Lack of Control over the Availability of CEHRT
  - Lack of Face-to-Face Patient Interaction

Significant Hardship Exceptions

- Medicare intends to address significant hardship exceptions for the AUC program through rulemaking for CY 2019
- The PAMA Act only allows the ordering professional to seek a significant hardship exception, not the furnishing professional.

Physicians May Earn MIPS Credit

- The “Final Rule for Quality Payment Program (QPP) Year 2” promises credit in the Medicare Incentive Based Payment System (MIPS) for physicians using Appropriate Use Criteria (AUC) through a qualified clinical support mechanism for all advanced diagnostic imaging services ordered.
- Use of AUC will be among the “Improvement Activities” which physicians may report under Patient Safety and Practice Assessment.

MIPS Improvement Activity

https://qpp.cms.gov/mips/improvement-activities

What's Next?

- Final sentence from the PAMA law:

"Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that includes a description of the extent to which appropriate use criteria could be used for other services under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.), such as radiation therapy and clinical diagnostic laboratory services."

Who has a head start on CDSM?

For Interesting Reading on Provider Experience using CDSM:

Summary of the ACR Stakeholder Meeting on Clinical Decision Support (CDS)

Held on January 20, 2016 in Washington, DC

https://acrbulletin.org/images/Downloads/WhitePaper.pdf

What's Next?

- Watch the 2019 Medicare Physician Fee Schedule Proposed Rule for further developments
- Work with your EHR vendor and radiologists to begin preparing the ordering medical staff for the reporting requirements
- When your ordering professionals begin consulting AUC, start reporting the QQ modifier as appropriate

Questions

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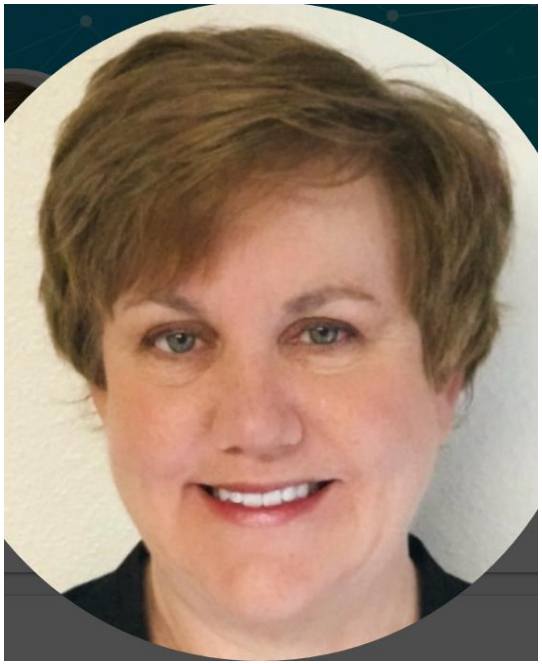
Contact Information



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Monica began her career in healthcare in 1995, after previous professional experience in cost analysis and contracts management in other industries.

Prior to joining PARA, Monica's career included nine years at PeaceHealth, an integrated delivery system in Washington State, in turns as Director of Contracts and Director of PFS; she also served as Business Office Director for Kaiser Permanente Northwest in Portland, Oregon, and Revenue Cycle Director for St. John's Medical Center in Jackson, Wyoming.

Monica has extensive experience in both physician and hospital revenue cycle operations, and she specializes in process improvement and making complex compliance issues understandable to all participants in the revenue cycle.

Monica joined PARA in April 2012 as Director of Audit, responsible for conducting Revenue Integrity Program meetings and providing onsite client audit services.