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Big Changes Coming for Radiologists with the Upcoming Mandate that Referring Physicians Consult Appropriate Use Criteria Prior to Ordering Advanced Imaging Services

Starting January 1, 2020, the Protecting Access to Medicare Act (PAMA) will require referring providers to consult appropriate use criteria (AUC)/clinical decision support (CDS) prior to ordering advanced diagnostic imaging services (ADIS) – including CT, MR, nuclear medicine exams and PET - for Medicare patients. What many radiologists are unaware of is that they, and the furnishing facilities, shoulder the burden for reporting the CDS system consultation on their medical claims for those services. Beginning January 1, 2021, payment will be denied in-full when the claims don't reflect this information as required – even if the ordering provider did not use the CDS system as mandated. The payment denials will apply to both the professional and technical components as well as charges billed globally. Interestingly, there is no financial penalty to the ordering physician who does not consult and document the use of AUC as required.

It's important to note that this program is not a Prior Authorization function. According to Medicare, consulting the AUC/CDS system at the point of care is intended to act as an educational tool. **Radiologists can still perform and receive payment for exams not considered appropriate through the consult, as long as the consult has been performed and reported on the radiologist's claim for the service.**

The program has struggled with delays and we are still waiting on key information from Medicare to understand how all aspects of it will be expected to play-out. But let's cover the basics as we know them today:

Who is required to perform the AUC/CDS consult?

- The ordering professional or a delegate from the clinical staff acting under his or her direction

How is the consult performed?

- Using a qualified Clinical Decision Support Mechanism (CDSM). The CDSM may be part of an existing EHR system or a stand-alone system, but must be certified by CMS as a qualified system

How will the furnishing radiologist and facility report the consult to Medicare?

- On their respective medical claims for the studies:
  - Medicare is anticipating creating a designated set of G codes to identify the CDSM used
  - Modifiers to identify exceptions and other specified factors
  - The NPI of the ordering practitioner

To what outpatient settings does the requirement apply?

- Physician's office
- Hospital outpatient department (including an Emergency department)
- Ambulatory surgical center
- Independent diagnostic testing facility

Information provided by APS Medical Billing, March 2019

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What are the exceptions that relieve the requirement of the consult?

- Inpatient services covered under Medicare Part A
- Services performed at a Critical Access Hospital
- Individuals with an 'emergency medical condition' regardless of the location where the services are performed. An emergency medical condition is defined as *a medical condition manifesting itself by acute symptoms of sufficient severity - including severe pain - such that the absence of immediate medical attention could reasonably be expected to result in:*
  - Placing the health of the individual (or an unborn child) in serious jeopardy
  - Serious impairment to bodily functions, or
  - Serious dysfunction of any bodily organ or part
- Additional hardship circumstances, requiring that a self-attestation be reported to the rendering radiologist to report on the claim with a designated modifier:
  - Insufficient internet access
  - EHR or CDSM vendor issues
  - Extreme and uncontrollable circumstances (including natural or manmade disasters)

What is the timeline of implementation?

- July 2018 – December 2019: voluntary reporting period
- January 2020: education and operations testing period begins (payments not affected)
- January 2021: start date (payments affected)
- January 2023 or 2024: Outliers identified

Now is the time to start working on this; don't let the timeline give you a false sense of security. Many in the industry are comparing the scope of this initiative to that of ICD-10 with good reason: there are multiple pieces to coordinate in a relatively short amount of time to prevent a hit to your payments. Consider the following for starters:

Referring Providers - How will the CDSM information be received from the ordering providers? How will orders missing this required information be handled?

Outpatient Hospital Patients - The flow of information for all applicable departments will have to be coordinated individually and training to the respective employees will have to take place. For example:

> Emergency department: Consults on ED patients are expected unless the patient's condition meets the definition of an emergency medical condition as described above; physicians and staff will need to know how to relay the needed information including how to identify these exceptions.
>
> Observation: Although technically Outpatients, patients in OBS are often in a hospital bed on the floor; the physicians and floor staff will need to be aware of this regulation as it is not part of their normal scope of practice today.

Billing Providers - How will this information be relayed to the biller to include on the claims to Medicare? Hospitals will need to rewrite their data exports and billers will need to rewrite their data imports to accommodate this additional information.

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Where to begin?

1. Resources

To familiarize yourself with the details, we recommend starting with the ACR at the following link that provides significant information and guidance:

https://www.acr.org/Clinical-Resources/Clinical-Decision-Support

2. Engage the referring physicians

AUC is not new but the PAMA regulation requiring the consult prior to ordering ADIS and reporting that consult to the furnishing provider is. The referral base would likely benefit from some general information to begin moving forward in creating a workable process.

CMS' Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Fact Sheet provides a comprehensive overview of the program that can help get things started. It is also available at the above ACR link.

3. Open communications with your hospital(s)

Radiologists don't control the systems in the hospital setting so it will be essential to identify the key hospital people (project leaders, I.T. staff, etc.) that will be in charge of implementation in the facility, HL7 files, etc., to maintain the flow of information throughout the process.

4. Work with your biller

All of the pieces coordinated will ultimately have to make it to your biller to make sure the needed information gets included on the claims to Medicare for your services.

APS has developed a work group for this initiative and will be reaching out to our clients in the coming weeks to begin laying the foundation for integrating this new mandate into the needed workflow processes. Please contact your APS Practice Manager with any questions.