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Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services Updates

Background: Medicare's Appropriate Use Criteria Program (AUC) went into effect on January 1, 2020 as an educational and operations test period. The program is slated to go into full-force effective January 1, 2022. Under the program, the ordering physician is required to consult a qualified Clinical Decision Support Mechanism (CDSM) when an advanced imaging service is ordered for a Medicare beneficiary and it will be furnished in an **applicable setting** as described below:

- Physician Office
- Hospital Outpatient Department (including Emergency Department)
- Ambulatory Surgical Center
- Independent Diagnostic Testing Facility
- Any other provider-led outpatient setting CMS determines appropriate

The applicable setting is where the imaging service is furnished, **not** where it was ordered. CMS clarified that AUC does not apply to MD waiver hospitals.

A CDSM is an interactive, electronic tool that communicates AUC information to the user to assist in making appropriate treatment decisions for a patient's specific clinical condition. The CDSM will provide the ordering provider with a determination of whether that order:

- Adheres to AUC;
- Does not adhere to AUC; or
- If there is no AUC applicable (e.g. no AUC for that patient's medical condition)

Computed Tomography, Magnetic Resonance Imaging, Nuclear Medicine and Positron Emission Tomography are all considered to be advanced imaging services. For a complete list of codes and more information, please click here.

The furnishing radiologist is responsible for billing the advanced imaging service through the use of designated modifiers and G codes on claims to Medicare. The billing provider will need to include the following when billing advanced diagnostic imaging:

- The CPT® or HCPCS code for the advanced imaging service.
- AUC Modifiers that report status of the consultation requirement; these modifiers are to be placed on the same line as the CPT code for the advanced imaging service. Please click here for a listing of applicable modifiers.
- The appropriate G-code (multiple can be reported on a single claim) that identifies the qualified CDSM consulted. This is reported as a separate line item that names the CDSM product used when reporting modifiers ME, MF or MG. For a full list of codes, please click here**.**
- The ordering providers NPI.

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When reporting modifiers that describe scenarios in which the ordering provider is exempt from having to consult a CDSM (e.g. MA. MB, MC, MD) no additional G- codes are needed.

The AUC program applies to the following payment systems:

- Physician fee schedule
- Hospital outpatient prospective payment system
- Ambulatory surgical centers

G-codes do not have associated payment rates, therefore it is expected that the MACs will adjudicate a no pay G-code line item with a CARC 246- This non-payable code is for required reporting only or RARC N620 Alert – This procedure code is for quality reporting/informational purposes only.

APS' AUC Work Group will provide further information about this initiative as released by Medicare and will continue working with our clients and their facilities to integrate this requirement into the needed data transmission and workflow processes. Please contact your APS Practice Manager with any questions.

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