Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-075		
Subject:	Appropriate Use Criteria for Advanced Diagnostic Imaging		
Effective Date:	May 29, 2023	**End Date:**	
Issue Date:	February 27, 2023	**Revised Date:**	
Date Reviewed:			
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☐	**WV**	☐	**DE**	☐	**NY**	☐
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☒	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b), established a new program to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries. Examples of such advanced imaging services include computed tomography (CT); positron emission tomography (PET); nuclear medicine, and magnetic resonance imaging (MRI).

This program impacts all physicians and practitioners (as defined in 1861(r) or described in 1842(b)(18)(C)), that order advanced diagnostic imaging services and physicians, practitioners and facilities that furnish advanced diagnostic imaging services in a physician's office, hospital outpatient department (including the emergency department), an ambulatory surgical center or an independent diagnostic testing facility (IDTF) and whose claims are paid pursuant to the physician fee schedule, hospital outpatient prospective payment system or ambulatory surgical center payment system.

This policy provides direction for Appropriate Use Criteria (AUC) to increase the rate of appropriate advanced diagnostic imaging services such as CT, PET, nuclear medicine, and MRI, established by The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b).

AUC present information in a manner that links a specific clinical condition or presentation; one or more services; and an assessment of the appropriateness of the service(s). 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 clinical presentation. For its purposes, AUC is a set or library of individual AUC. Each individual criterion is an evidence-based guideline for a particular clinical scenario based on a patient presenting symptoms or condition.

AUC need to be integrated as seamlessly as possible into the clinical workflow. Clinical Decision Support Mechanisms (CDSMs) are the electronic portals through which clinicians access the AUC during the patient workup. They can be standalone applications that require direct entry of patient information but may be more effective when they are integrated into electronic health records (EHRs). Ideally, practitioners would interact directly with the CDSM through their primary user interface, thus minimizing interruption to the clinical workflow.

The guidelines outlined in this policy are a recommendation for the Plan's providers to begin adopting and utilizing. These guidelines will become a mandatory practice for providers to adhere to in the future.

REIMBURSEMENT GUIDELINES:

At the time a practitioner orders an advanced imaging service for a member, it is recommended that he/she consult a qualified CDSM. CDSMs are the electronic portals through which practitioners access AUC during the patient workup. The CDSM will provide the ordering professional with a determination of whether the order adheres, or does not adhere, to AUC, or if there is no AUC applicable.

It is also recommended a consultation take place for an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting. Please note that the applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered.

Consultation with a qualified CDSM is recommended with detailed information regarding the ordering professional's consultation appended to the furnishing professional's claim and with modifier QQ also appended to the impacted claim line(s). This includes the ordering practitioner's National Provider Identifier (NPI) and documenting which CDSM was consulted (there are multiple qualified CDSMs available). Exceptions to consulting CDSMs include:

- The ordering professional having a significant hardship,
- Situations in which the patient has an emergency medical condition, or,
- An applicable imaging service ordered for an inpatient, which reimbursement is made under Part A.

Note: If the above exceptions apply, append the appropriate modifier on the claim line(s). A full list of modifiers is listed in the definition section of this policy.

Modifier QQ should be appended to <u>both</u> facility and professional claim lines under the circumstances below:

- When the furnishing professional is aware of a consultation with a CDSM for that patient,
- Reported on the same claim line as the CPT code for an advanced diagnostic imaging service furnished in an applicable setting.

Note: For institutional claims, edits only apply to type of bill 13X.

Applicable settings include:

- Physician office(s)

- Hospital outpatient departments (including emergency departments) and on-campus and off-campus provider-based departments
- Ambulatory surgical centers (ASCs)
- Independent diagnostic testing facilities

Note: The applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered.

Applicable Codes:

Magnetic Resonance Imaging

70336	70540	70542	70543	70544	70545	70546	70547	70548	70549
70551	70552	70553	70554	70555	71550	71551	71552	71555	72141
72142	72146	72147	72148	72149	72156	72157	72158	72159	72195
72196	72197	72198	73218	73219	73220	73221	73222	73223	73225
73718	73719	73720	73721	73722	73723	73725	74181	74182	74183
74185	75557	75559	75561	75563	75565	76498	77046	77047	77048
77049									

Computerized Tomography

70450	70460	70470	70480	70481	70482	70486	70487	70488	70490
70491	70492	70496	70498	71250	71260	71270	71275	72125	72126
72127	72128	72129	72130	72131	72132	72133	72191	72192	72193
72194	73200	73201	73202	73206	73700	73701	73702	73706	74150
74160	74170	74174	74175	74176	74177	74178	74261	74262	74712
74713	75571	75572	75573	75574	75635	76380	76497		

Single-Photon Emission Computed Tomography

76390

Nuclear Medicine

78012	78013	78014	78015	78016	78018	78020	78070	78071	78072
78075	78099	78102	78103	78104	78110	78111	78120	78121	78122
78130	78135	78140	78185	78191	78195	78199	78201	78202	78215
78216	78226	78227	78230	78231	78232	78258	78261	78262	78264
78265	78266	78267	78268	78278	78282	78290	78291	78299	78300
78305	78306	78315	78350	78351	78399	78414	78428	78429	78430
78431	78432	78433	78434	78445	78451	78452	78453	78454	78456
78457	78458	78459	78466	78468	78469	78472	78473	78481	78483
78491	78492	78494	78496	78499	78579	78580	78582	78597	78598
78599	78600	78601	78605	78606	78608	78609	78610	78630	78635
78645	78650	78660	78699	78700	78701	78707	78708	78709	78725
78730	78740	78761	78799	78800	78801	78802	78803	78804	78811

78812 78813 78814 78815 78816 78830 78831 78832 78835 78999

C-codes

C8900 C8901 C8902 C8903 C8905 C8908 C8909 C8910 C8911 C8912
C8913 C8914 C8918 C8919 C8920 C8931 C8932 C8933 C8934 C8935
C8936

Claims that report HCPCS modifier ME, MF, or MG, on the Advanced Diagnostic Imaging Services claim line should additionally contain a G-code on a separate claim line to report which qualified CDSM was consulted. Since G-codes are not separately reimbursed and only used for reporting, the Plan will process them with an appropriate rejection message that is non-billable to the member.

Note: Multiple G codes on a single claim is acceptable.

Applicable Codes:

G1000 G1001 G1002 G1003 G1004 G1005 G1006 G1007 G1008 G1009
G1010 G1011

DEFINITIONS:

Term	Definition
Appropriate Use Criteria (AUC)	Criteria only developed or endorsed by national professional medical specialty societies or other provider-led entities, to assist ordering professionals and furnishing professionals in making the most appropriate treatment decision for a specific clinical for an individual. To the extent feasible, such criteria must be evidence-based. An AUC set is a collection of individual appropriate use criteria. An individual criterion is information presented in a manner that links: a specific clinical condition or presentation; one or more services; and an assessment of the appropriateness of the service(s).
Specified Applicable AUC	Any individual appropriate use criterion or AUC set developed, modified, or endorsed by a qualified provider-led entity (PLE).
Furnishing Professional	A physician or a practitioner who furnishes an applicable imaging service.
Ordering Professional	A physician or a practitioner who orders an applicable imaging service.
Furnishing Professional	A physician or a practitioner who furnishes an applicable imaging service.
Priority Clinical Areas	Clinical conditions, diseases, or symptom complexes and associated advanced diagnostic imaging services identified by The Centers for Medicare and Medicaid Services (CMS) through annual rulemaking and in consultation with stakeholders which may be used in determination of outlier ordering professionals.
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.
Qualified Provider-led Entity	To be qualified, a PLE must adhere to the evidence-based processes when developing or modifying AUC. A qualified PLE may develop AUC, modify AUC developed by another qualified PLE, or endorse AUC developed by other qualified PLEs.

Modifier 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.
Modifier MB	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access.
Modifier 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.
Modifier MD	Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances.
Modifier ME	The order for this service adheres to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional.
Modifier 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.
Modifier MG	The order for this service does not have appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional.
Modifier 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.
Modifier QQ	Ordering professional consulted a qualified clinical decision support mechanism for this service and related data was provided to the furnishing professional.

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-008: X-rays Using Film, Computed Radiography-Tomography Mods FX, FY, CT

REFERENCES:

- The Protecting Access to Medicare Act (PAMA) of 2014, Section 218(b)
- Center for Medicare and Medicaid Services (CMS); MLN Matters Publication Number MM11268; transmittal 2404OTN, change request 11268
- Center for Medicare and Medicaid Services (CMS); Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program
- Center for Medicare and Medicaid Services (CMS); Calendar Year 2022 Final Rule; pg. 65224-65241

POLICY UPDATE HISTORY INFORMATION:

5 / 2023	Implementation