THE CMS APPROPRIATE USE CRITERIA PROGRAM

The provider's handbook

PART 2

What you need to know about the CMS Appropriate Use Criteria Program

AIM INFORM

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For health systems and large provider groups, the CMS Appropriate Use Criteria (AUC) Program has the potential to introduce notable changes across your entire system. Its requirements, which go into effect January 1, 2020, may mean your system needs to modify critical workflows and make some difficult decisions, ranging from financial ones, like how to shift administrative resources, to clinical and technical ones, like which qualified clinical decision support mechanism (qCDSM) to invest in.

But before you can tackle these dilemmas, you'll need a basic understanding of the program, its implications, and its relationship to other utilization-based programs, like CDS and prior authorization.

What, exactly, is the CMS AUC Program?

Directed by the Protecting Access to Medicare Act of 2014 (PAMA), CMS established the CMS AUC Program to promote appropriate use criteria for outpatient advanced imaging. The goal of the program is to improve the quality of care and reduce inappropriate imaging for Medicare fee-for-service beneficiaries.

To comply, ordering providers need to consult AUC developed by a CMS-designated provider-led entity (PLE) through a qualified clinical decision support mechanism (qCDSM), or tool, when ordering any advanced imaging service, such as MRI, CT, nuclear medicine (including PET), for these beneficiaries. The furnishing providers, including ambulatory imaging centers and hospital outpatient centers, are responsible for reporting (through the use of G-codes and modifiers) that AUC were consulted. The G-codes and modifiers will be reported on claims.

SNAPSHOT

STARTS JANUARY 1, 2020

Goal Improve the quality of care and reduce inappropriate advanced imaging for Medicare fee-for-service beneficiaries

Requirement Physicians or their delegates must consult appropriate use criteria using a CMS-approved tool. Furnishing providers must report this consultation to avoid reimbursement denials.

Affected population Medicare fee-for-service beneficiaries only

Impacted workflows Clinical, revenue cycle, and patient scheduling

Why the program deserves a spot on your strategic agenda

The aim of the Medicare program is praiseworthy and needed, but the implications for your health system are significant, with the potential to impact your revenue and your physicians' workflows. Here are four implications to keep top of mind.

1. **The potential for reimbursement denials**

   CMS will penalize imaging providers who fail to report AUC consultation on claims.

2. **Workflows likely to change**

   Consulting the criteria and ensuring the proper reporting code on the claim represent additional steps within your clinicians' and your administrative teams' already complex processes.

3. **More authorization measures for outliers**

   In 2022 or 2023, the CMS program will identify five percent of ordering providers as outliers, who will be subject to prior authorization for advanced imaging. 2020 is considered an education and operations testing year and will not be included in the outlier methodology analysis.

4. **MIPS credit available**

   Providers can earn credit for the Merit-based Incentive Payment System, or MIPS, when they consult a qualified CDS mechanism, which CMS recognizes as a high-weighted improvement activity. This credit is available now even before the program officially begins in 2020.

The CMS AUC Program vs. prior authorization

The CMS AUC Program joins a list of efforts, such as payer prior authorization programs, designed to reduce inappropriate advanced imaging. On the surface, these resemble one another—in each, providers refer to clinical criteria to help them deliver quality, evidence-based care. However, digging deeper, you'll uncover some important differences in the CMS program.

1 Providers need to only consult criteria, not follow it

With prior authorization, providers generally receive reimbursement only when they align care with a health plan's clinical criteria. However, the CMS AUC Program does not require providers to align care with the AUC's recommendation, only that they consult it.

2 No escalation, like a physician review, exists with the AUC Program

With most prior authorization programs, clinicians may need to escalate a patient's case if they disagree with the clinical review's determination. For example, with prior authorization, the clinician may need to speak with a physician reviewer from the health plan to validate their request. With the CMS AUC Program, no concept of escalation exists.

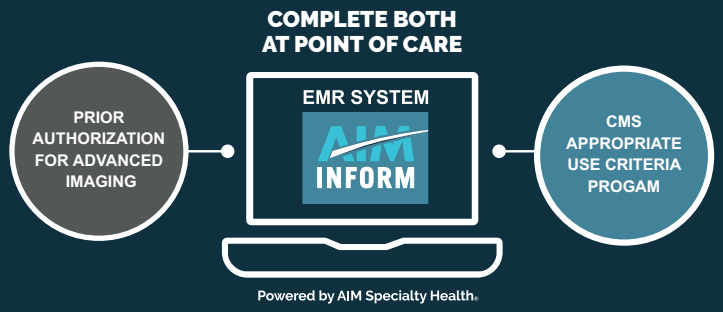
3 CMS will not match up patient files with membership files

For the AUC Program, CMS does not supply any membership files that providers can use to match up with patient files. In other words, providers will need to determine which of their patients are eligible for the AUC Program.

4 Choosing an imaging facility is up to you

Many payer prior authorization programs, require you to select an imaging facility in their network, or restrict imaging to non-hospital settings. In contrast, the CMS AUC Program does not include facility selection in the program workflow.

For more than 25 years, AIM Specialty Health has helped ensure that advanced imaging aligns with medical evidence. Through our AIM Inform solution, a CMS qCDSM, we now help health systems and other provider organizations comply with the CMS AUC Program and commercial payer preauthorization within the EMR systems they use every day.



Integrated into EMR systems, AIM Inform allows providers to complete prior authorization for advanced imaging and comply with the CMS Appropriate Use Criteria Program from a single source.

AIM Inform eliminates the need for providers to use separate systems to fulfill prior authorization and CMS program requirements.

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