

Imaging Appropriate Use Claims Requirement Expanse

Release(s)

Expanse 2.1 pp 17 Expanse 2.2 pp 4

Overview

Within Expanse Order Management (OM) and Ambulatory (AMB), providers have the ability to perform an imaging appropriateness check through integration with the National Decision Support Company (NDSC). Imaging appropriateness scores can also be entered manually through the Scheduling to Order link in Community Wide Scheduling (CWS) and in Imaging and Documentation Management (IDM). Orders entered outside of the MEDITECH EHR may utilize a different Clinical Decision Support Mechanism (CDSM). This setup guide outlines the workflows for Vendor G-Codes, adherence and exception modifiers, and covers the associated MIS Parameter setup. The setup for the Revenue Cycle Management (RCG) application can be referenced in the Imaging Appropriate Use Criteria (AUC) Claims Billing Setup Guide.

MEDITECH Applications

- Ambulatory (AMB)
- Community Wide Scheduling (CWS)
- Emergency Department Management (EDM)
- Management Information Systems (MIS)
- Imaging and Documentation Management (IDM)
- Order Management (OM)
- Revenue Cycle Management (RCG)

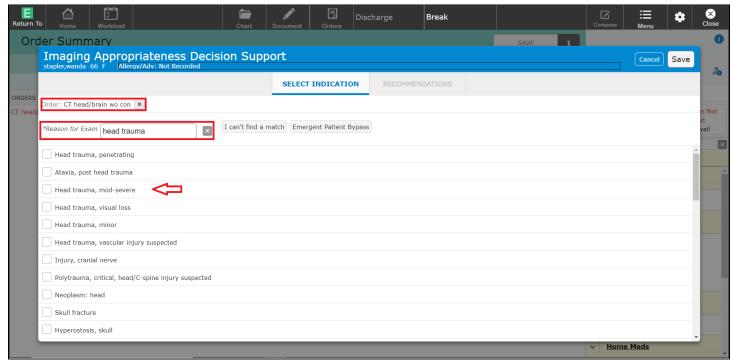
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MEDITECH's Recommended Workflow

Procedure adheres to Appropriate Use Criteria

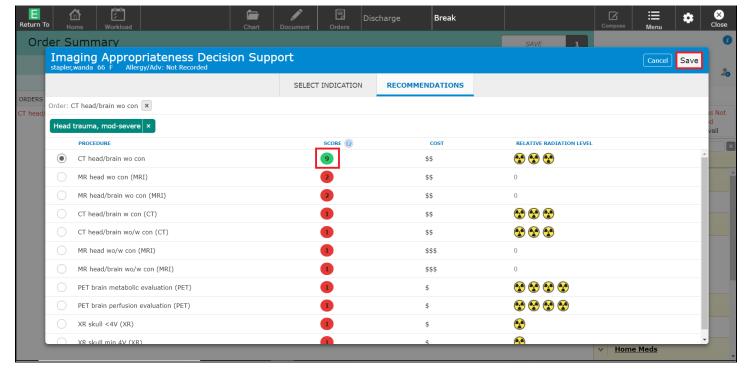
The provider accesses the Orders button and places an AUC-eligible procedure. Upon saving, the Imaging Appropriateness Decision Support overlay appears. The response to the reason for exam query seeds the indication list and the provider selects the clinical indication.

Clinical > Web Acute Status Board > Order



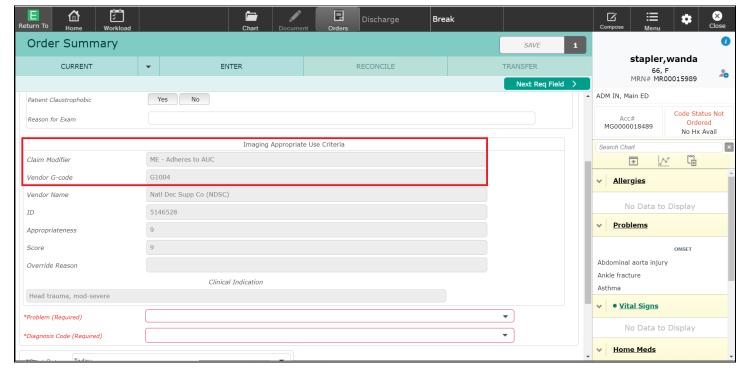
Based on the clinical indication selected, the CT head/brain wo con order receives a score of 9; indicating that it is an appropriate exam. The provider saves the order.

Clinical > Web Acute Status Board > Orders



The Claim Modifier of ME is appended to the order as this procedure 'Adheres to Appropriate Use Criteria'. The G-Code G1004 is applied identifying the CDSM as the NDSC.

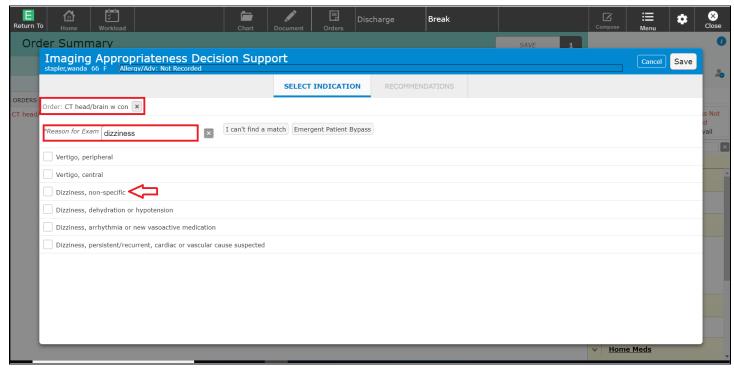
Clinical > Web Acute Status Board > Orders



Procedure Does Not Adhere to Appropriate Use Criteria

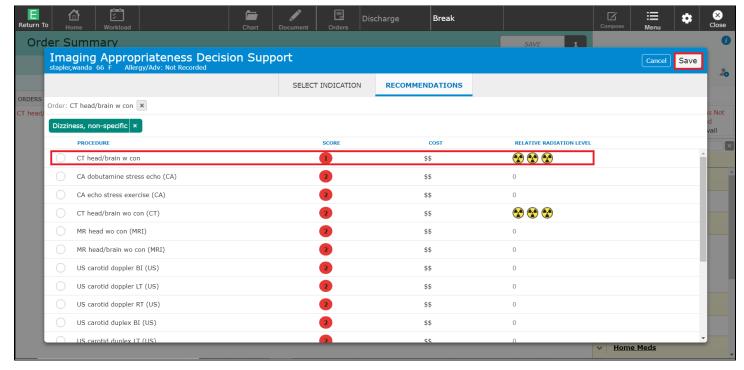
The provider clicks the Orders button and places an AUC-eligible procedure. Upon saving, the Imaging Appropriateness Decision Support overlay appears. The response to the reason for exam query seeds the indication list and the provider selects the clinical indication.

Clinical > Web Acute Status Board > Order



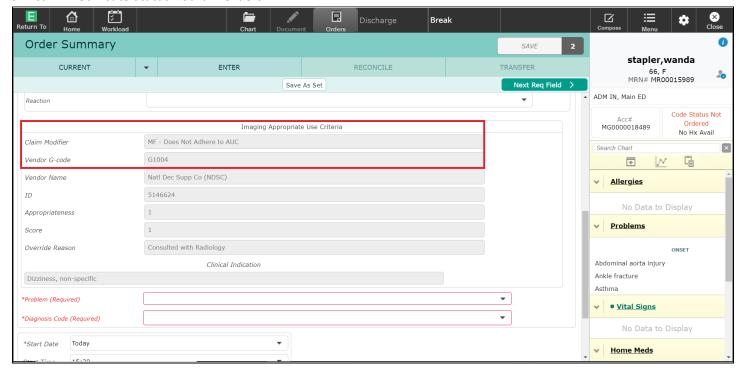
Based on the clinical indication selected, the CT head/brain w con order receives a score of 1 indicating that it's not appropriate.

Clinical > Web Acute Status Board > Orders



The provider chooses to order the exam anyway, and answers the override reason screen. The Claim Modifier of MF is appended to the order as this procedure 'Does Not Adhere to Appropriate Use Criteria.' The G-Code G1004 is applied; identifying the CDSM as the NDSC.

Clinical > Web Acute Status Board > Orders

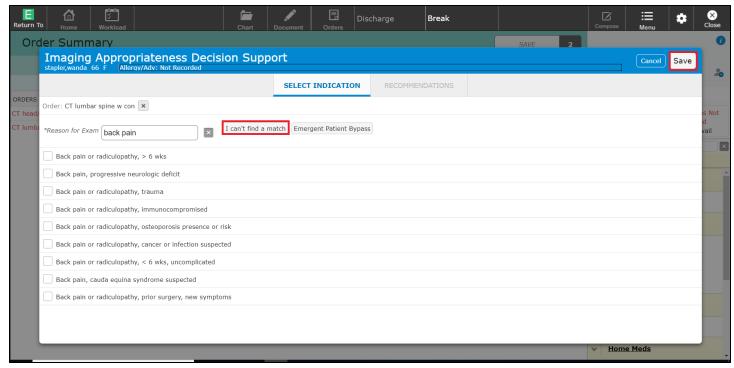


No AUC Available (No Match/No Score/No Content/Unmapped)

There are four situations where an order receives an MG modifier as there is no AUC available for the order. These scenarios are:

- Provider selects 'I can't find a match' as none of the clinical indications match their reason for ordering the exam.
- The exam and indication combination produces *No Score*. This means that the Provider Led Entities do not have a consensus on whether this procedure is appropriate or not for the selected indication.
- The exam is known to NDSC (mapped), but there is no appropriateness content for the exam on the NDSC side.
- The exam is not known to NDSC (unmapped). As NDSC maps new/edited procedures on a bi-yearly basis, there is a potential for AUC-eligible orders to be unknown to NDSC when ordered.
 - In these situations, an error is presented to the user: procedure not mapped to CDSM, and the MG modifier is applied. Once the new or edited exams are mapped by NDSC, the proper modifier is applied based on the score.

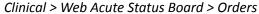
Clinical > Web Acute Status Board > Orders

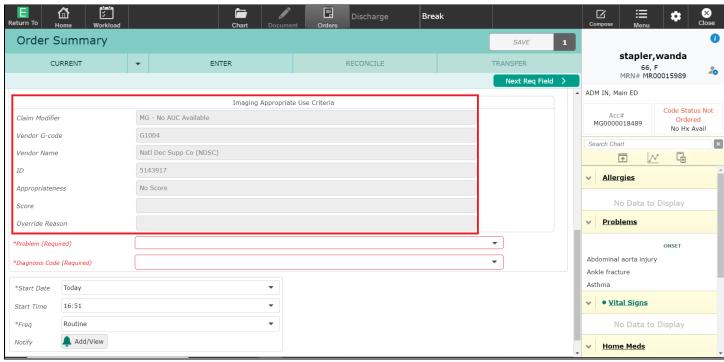


MEDITECH - 8 of 31 Last Updated: May 13, 2021 In all situations where there is no AUC available, the order receives an MG modifier.

Additional Notes

- No Content exams do not require the user to interact with the AUC overlay. In the background, the Vendor,
 G-Code, and MG modifier are automatically applied. There is no value in the Appropriateness or Score fields. The
 exception to this is the Ambulatory application. In AMB, the appropriateness value of No Score is populated for
 No Content exams.
- For a *No Score* exam, the user interacts with the AUC overlay to allow selection of a Clinical Indication, in case that changes the score. Once one is selected, if there is no score, it displays as:

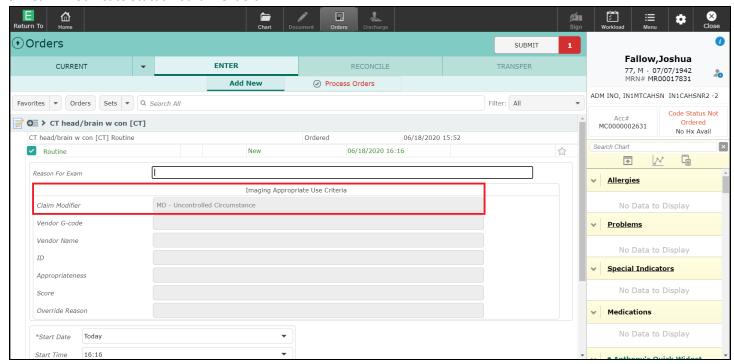




Extreme & Uncontrollable Circumstances

CMS allows an exception to reporting AUC in the event of extreme and uncontrollable circumstances. A parameter can be set by facility to temporarily bypass AUC checking for all patients and exams. In this situation, providers are not launched to the AUC overlay, and the MD modifier is applied to the order in the background. The facility is then removed from the parameter when the extreme or uncontrollable circumstance has passed.

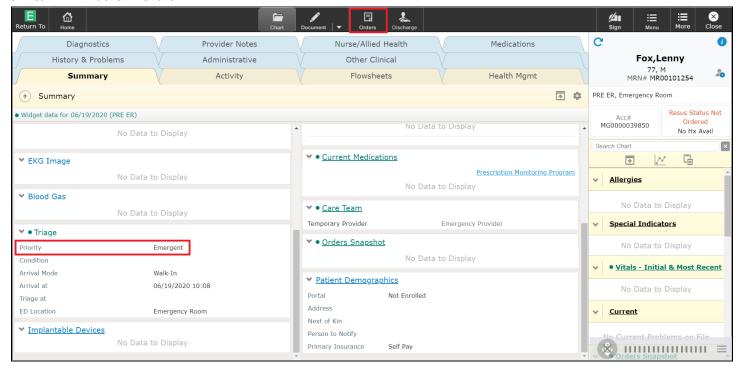
Clinical > Web Acute Status Board > Orders



Emergency Exception

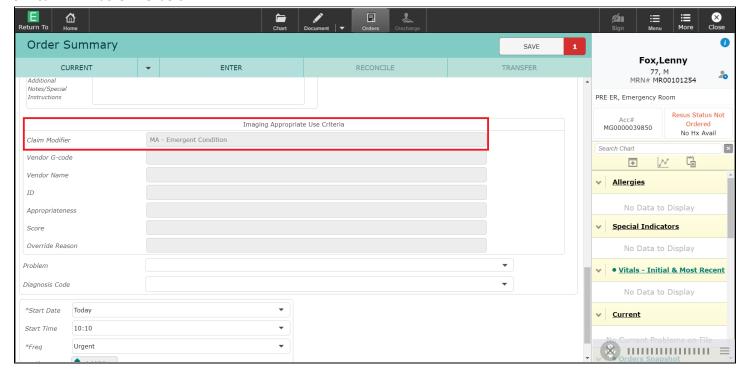
CMS allows an exception to reporting AUC for patients with certain emergency medical conditions. See <u>Section</u> <u>1867(e)(1)</u> of the Act for further clarification on what is considered an emergency medical condition. ED priorities can be defined in the M-AT Parameters as ED Priority Exceptions.

Clinical > ED Tracker > Chart



When the patient's ED priority is listed in the Emergency Bypass parameter, the AUC overlay does not appear. The MA modifier is added to the order in the background. If the patient is then rolled into an *Inpatient* or *Observation* patient, the ED Exception no longer applies.

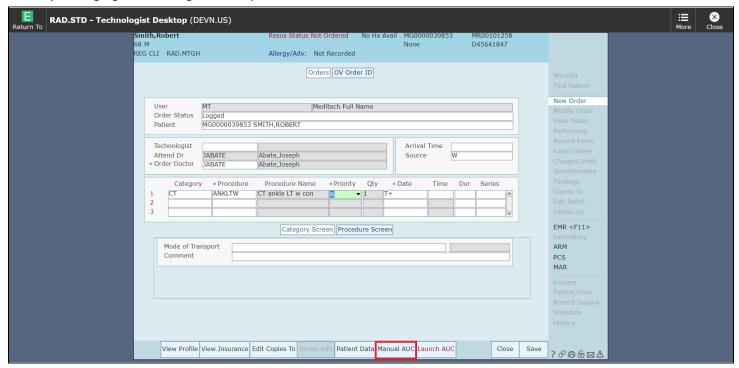
Clinical > ED Tracker > Orders



Manual Entry

The manual entry screen has two new fields to allow the user to select the G-Code and the claim modifier.

Ancillary > Imaging > Technologist Desktop > New Order

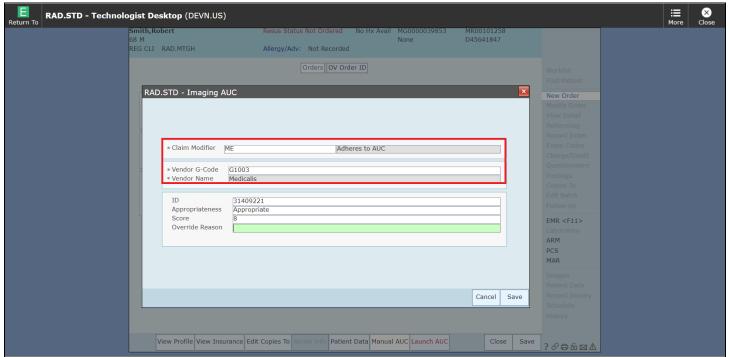


The user selects the applicable *Claim Modifier* and *Vendor G-Code* from the group response lookups. After selecting the Vendor GCode, the Vendor Name is automatically populated. The *ID*, *Appropriateness*, *Score*, and *Override Reason* fields are unchanged and are entered by the user, if provided. These are not required fields. If the Claim Modifier selected is one of the Exception modifiers (MA, MB, MC, MD), the Vendor G-Code is not required. If no AUC is provided with the order, the modifier of MH is applied and the Vendor G-Code is not required. Vendor G-Code is required for the modifiers of ME (Adheres to AUC), MF (Does not Adhere to AUC), and MG (No AUC Available).

Additional Note

When the Vendor G-Code G1011 'Clinical Decision Support Mechanism, qualified tool not otherwise specified' is selected, the *Vendor Name* field is editable. The user can enter a *Vendor Name* or choose "This is a new vendor."

Ancillary > Imaging > Technologist Desktop > New Order > Manual AUC



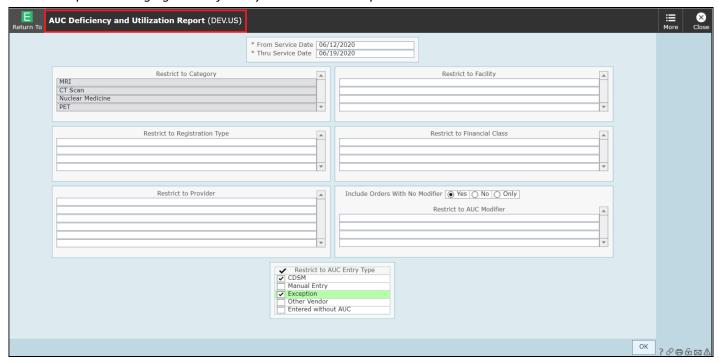
Monitoring Utilization & Deficiencies

The Imaging AUC Deficiency report was enhanced to include utilization information as well as deficiencies. Selection criteria includes:

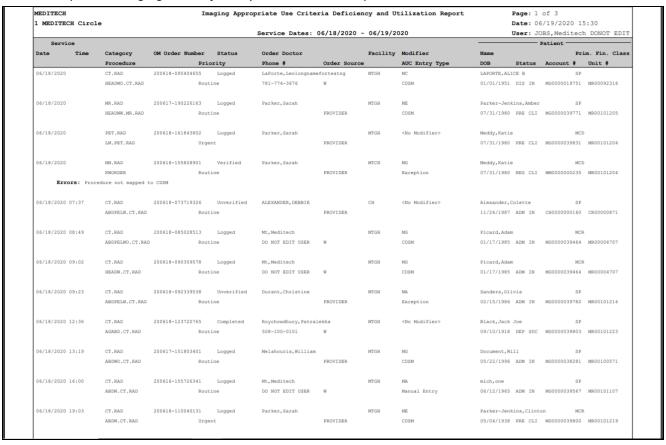
- Service date range
- Restrict to categories
- Restrict to facility
- Restrict to registration types
- Restrict to financial classes
- Restrict to provider(s)
- Include orders with specific modifier(s) or no modifiers
- Restrict to AUC entry type
 - CDSM: Orders placed in MEDITECH using the NDSC integrated solution
 - o Manual entry: Orders placed outside of MEDITECH where AUC values are manually entered on the order
 - o Exception: Orders where AUC was bypassed due to significant hardship
 - Other Vendor: Orders placed in an Other Vendor system interfaced into MEDITECH with AUC values
 - Entered without AUC: Orders eligible for AUC checking where the provider did not complete the AUC consultation

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Clinical > Reports > Imaging AUC Deficiency and Utilization Report



Clinical > Reports > Imaging AUC Deficiency and Utilization Report



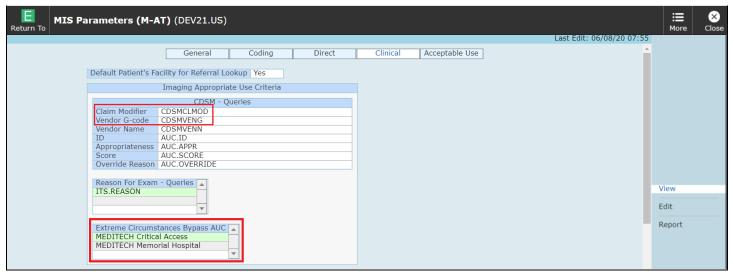
Setup

MIS Clinical Parameters

Query fields for Claim Modifier and Vendor G-Codes are available in the list of CDSM queries. New queries for the Claim Modifier and Vendor G-Code should be created and added to the fields to facilitate the manual entry of AUC values. Once defined, the query mnemonics cannot be changed. If necessary, edits can be made to the group responses. The <u>AUC Claims Processing Requirements Guide</u> available on CMS.gov can be referenced for details on the Vendor G-Codes and Adherence Modifier values.

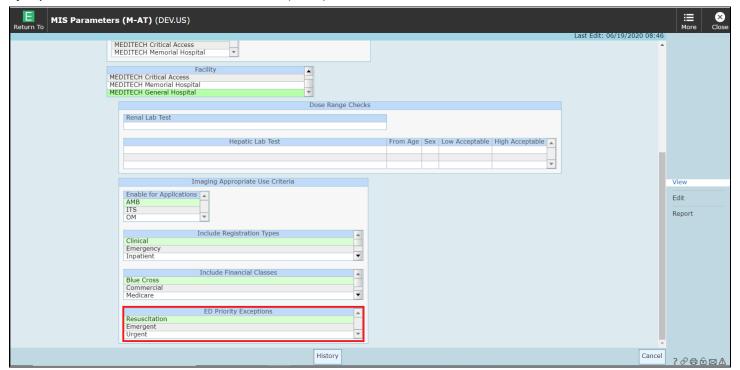
The Extreme Circumstances Bypass AUC parameter was added to allow for the significant hardship exception of extreme and uncontrollable circumstances. This field looks to the MIS Facility Dictionary, and is restricted to non-ambulatory facilities. When a facility is defined in the parameter, AUC-checking is bypassed for that facility, and the MD modifier and descriptor are automatically added to the order. This functionality applies to users with access to Check CDSM only.





A new ED Priority Exceptions parameter was added to allow for the Emergency Exception. This field is available to be defined for non-ambulatory facilities and looks to the ED Priority Dictionary. When an ED priority is defined, the AUC check is suppressed and the MA modifier and descriptor are automatically added to the AUC-eligible order. This applies to users with access to Check CDSM as well as users without access to Check CDSM.

Info Systems > MIS > Dictionaries > Parameters (M-AT)



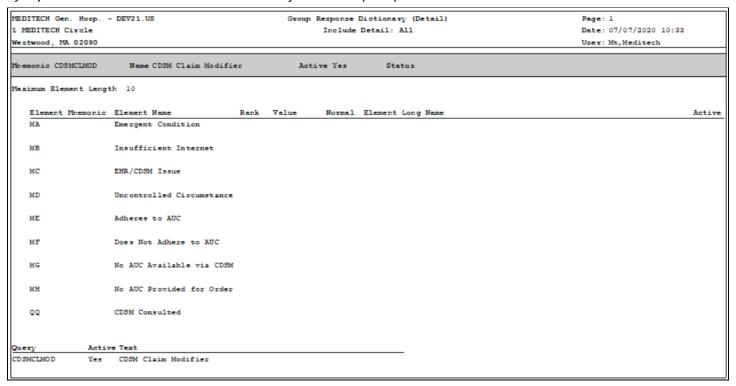
MIS Group Response Query

New Group Response queries should be created for claim modifiers and vendor g-code. An Optional type query is required for vendor name. The examples below were sourced from CMS.gov and abbreviations were applied where needed.

Modifier Query

A new group response query for modifier should be created. The group response entries are defined based on the adherence modifiers provided by CMS.

Info Systems > MIS > Dictionaries > Customer Defined > Group Response



Vendor G-Code Query

A new group response query should be created for vendor G code. The group response entries are defined based on the vendor G codes provided by CMS.

Vendor G-Code Query

Info Systems > MIS > Dictionaries > Customer Defined > Group Response

MEDITECH Gen. Hosp 1 MEDITECH Circle Westwood, MA 02090	DEV21.US		nse Dictionary (Deta ude Detail: All	Page: 1 Date: 07/07/2020 11:09 User: Mt, Meditech			
Mnemonic CDSMVENG	Name CDSM Vendor G-Code	Active Ye	s Status				
Maximum Element Length 10							
Element Mnemonic	Element Name Rank	Value Nor	mal Element Long Na	ame Activ			
G1001	eviCore healthcare						
G1002	MedCurrent OrderWise						
G1003	Medicalis						
G1004	NDSC CareSelect						
G1005	Natl Imaging Assoc RadMD						
G1006	Test Appropriate						
G1007	AIM Specialty Health						
G1008	Cranberry Peak esCDS						
G1009	Sage Health Mgmt RadWise						
G1010	Stanson CDS						
G1011	Not Otherwise Specified						
G1012	AgileMD's CDSM						
G1013	EvidenceCare Imaging Adv						
G1014	InveniQA Semantic Answers						
G1015	Reliant Medical Group						
G1016	Speed of Care						
G1017	HealthHelp						
G1018	INFINX						

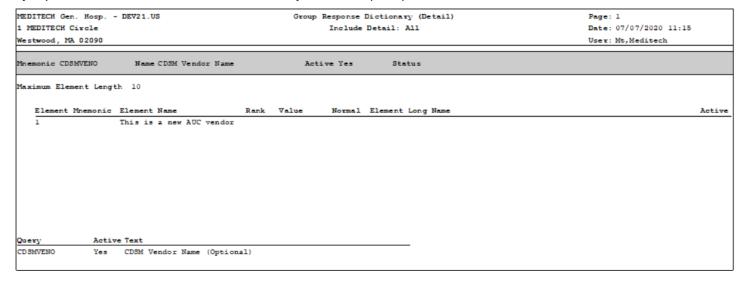
MEDITECH Gen. 1	Horn -	DEU21 IIS	Group Response Dictionary (Detail)	Page: 2
MEDITECH Cir	•	DEV21.00	Include Detail: All	Date: 07/07/2020 11:09
Westwood, MA 0:				User: Mt, Meditech
G1019	1	LogicNets AUC Solution		
Query	Active	Text		
CD SMVENG			11	
		CDSM Vendor G-Code (Opti		
CDSMVENGG	Yes	CDSM Vendor G-Code (Grow	Response)	

In the case where the CDSM vendor is not provided or does not appear on the list of Vendor G-Codes, the G-Code of G1011 can be applied and the vendor name can be entered, or the response: "this is a new AUC vendor" can be chosen.

Vendor Name (Unspecified G-Code/Vendor)

A new optional group response query should be created for Vendor name. The optional query allows users to free text in the vendor name or choose "this is a new vendor" from the associated group response.

Info Systems > MIS > Dictionaries > Customer Defined > Group Response



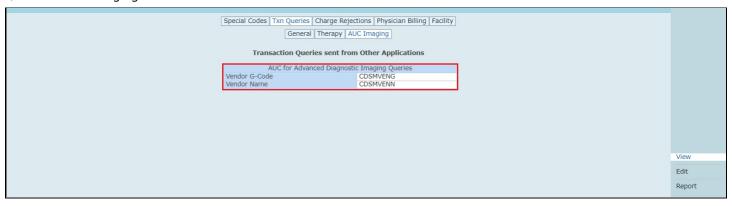
Revenue Cycle: Required AUC Setup

Prior to any setup in Revenue Cycle, it should be confirmed that the CDSM G-Code and Vendor Name queries were created in MIS and attached to the MIS Clinical Parameters per the previously mentioned setup.

Charge Description Master Parameters

Define the Vendor G-Code and Vendor Name queries that were defined in the MIS Customer Parameters. When the AUC Claim Type is set up, the Claim programs references these queries to report the AUC data in the appropriate claim fields. **Note:** Vendor Name is only needed if reporting G-Code G1011.

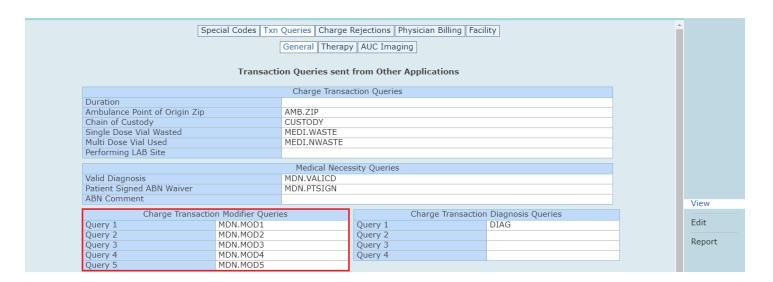
Financial > Patient Accounting > Dictionaries > Batch > Code Support > Charge Description Master Parameters > Txn Queries > AUC Imaging



Ensure the standard Charge Transaction Modifier Queries are defined in the Charge Description Master Parameters using the standard values of MDN.MOD1 - MDN.MOD5.

*MEDITECH Specialist will confirm MIS Toolbox NPR Parameters match the standard queries as defined below.

Financial > Patient Accounting > Dictionaries > Batch > Code Support > Charge Description Master Parameters > Txn Queries > General



Customer Defined Screen (CDS) Setup & Batch Entry Requirements:

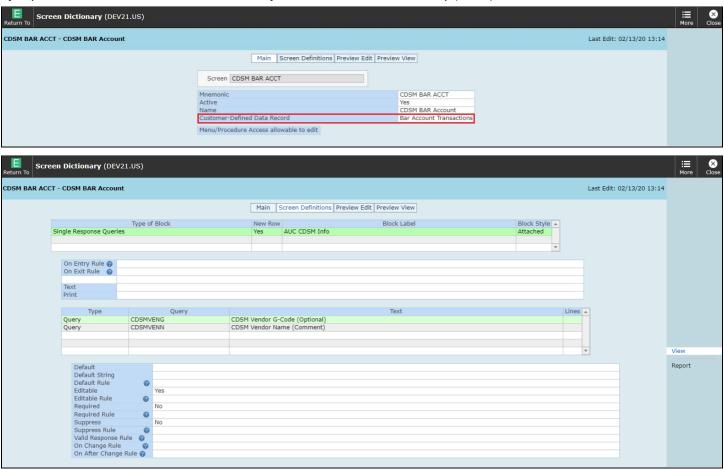
This following guide outlines the setup in Patient Accounting to create the Customer Defined Screens that contain the CDSM G-Code and Vendor Name queries, and how to appropriately capture the AUC data in batches and transactions, which will be reported on your claims.

CDS Creation

Two screens will need to be created to which both of the queries will need to be attached (CDSMVENG/CDSMVENN), one CDS for the BAR Account Transactions Record and one CDS for the BAR Batch Transactions Record.

Screen Setup - BAR Account Transactions Record:

Info Systems > MIS > Dictionaries > Custom Defined Data > Screen Dictionary (M-AT)

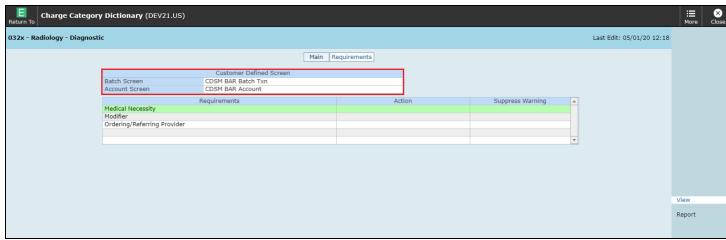


The above setup will need to be repeated for the BAR Batch Transactions Record.

Attaching the CDS to the Charge Category Dictionary & Charge Description Master (CDM)

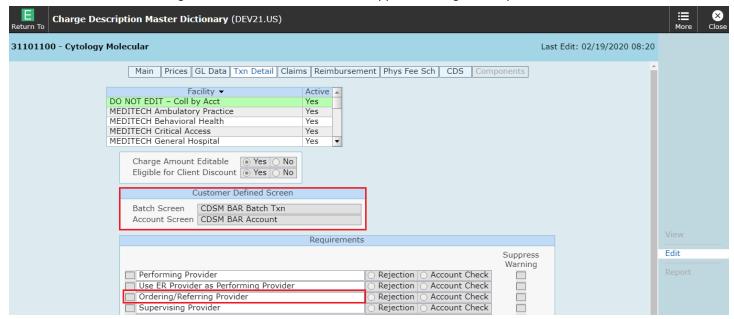
After the creation of the two CDSs, both will need to be attached in either the Charge Category Dictionary or CDM. When defined at the Charge Category level, the CDS is available for all charge codes with this charge category. The queries display on all the charges for this category, and will allow for entering and editing. Otherwise, the CDSs can be defined on specific charge codes in the CDM.

Financial > Patient Accounting > Dictionaries > Batch > Code Support > Charge Category Dictionary > Requirements



Customer Defined Screens can also be defined at the charge code level in the CDM on the Txn Detail Tab; *Customer Defined Screen* field. Charge codes with the CDSs defined here display the queries and allow for entering and editing.

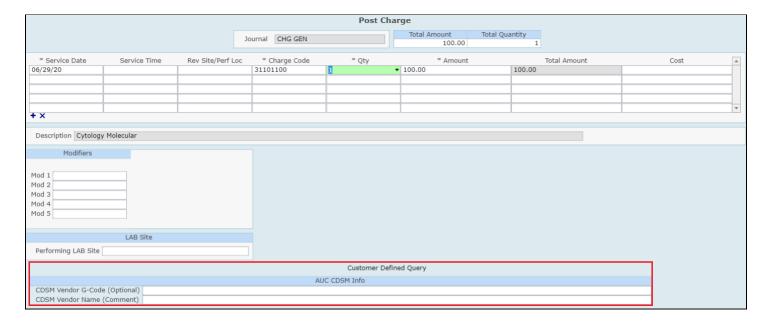
Financial > Patient Accounting > Dictionaries > Batch > Code Support > Charge Description Master > Txn Detail



NOTE: Ensure the Transaction Detail Requirement "Ordering/Referring Provider" is selected for all imaging charges in the Charge Description Master dictionary or for all imaging charge Revenue Codes in the Charge Category dictionary.

Batch Entry

Once the setup of the CDSs is complete, they can then be used during charge entry either through the Batch Desktop or through using Quick Transactions in the Patient Accounting Desktop. After a charge is posted to an account using either of these posting methods, the queries can be accessed and updated if needed through the Txn Detail Routine of the Patient Accounting Desktop. See example of charge entry using Quick Transactions in the Patient Accounting Desktop with newly available CDS and Queries below.

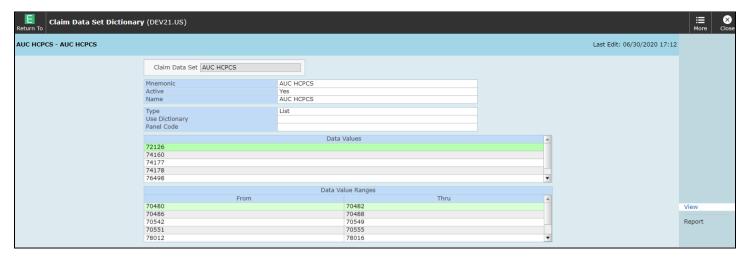


Revenue Cycle: Claim Setup

Claim Data Set Creation

Two data sets need to be created to be attached to the Claim Format and can also be utilized with Account Checks. The first Data Set is the AUC HCPCS/CPT list. This is a list of HCPCS/CPT codes that need to report the AUC modifier and G-Code. The second Data Set is the AUC Modifier list. This should contain the MA, MB, MC, MD, ME, MF, MG, MH, and QQ modifiers that will be referenced by the claim for the AUC modifier placement.

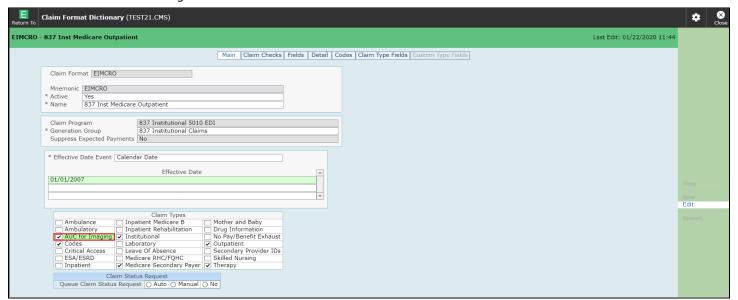
Financial > Patient Accounting > Dictionaries > Claim > Data Set



Claim Format Dictionary - Main Screen

To report AUC information on the claim, the AUC For Imaging Claim Type needs to be selected on the Main Screen of the Claim Format Dictionary. This will enable the fields on the Claim Type Fields tab.

Financial > Patient Accounting > Dictionaries > Claim > Format



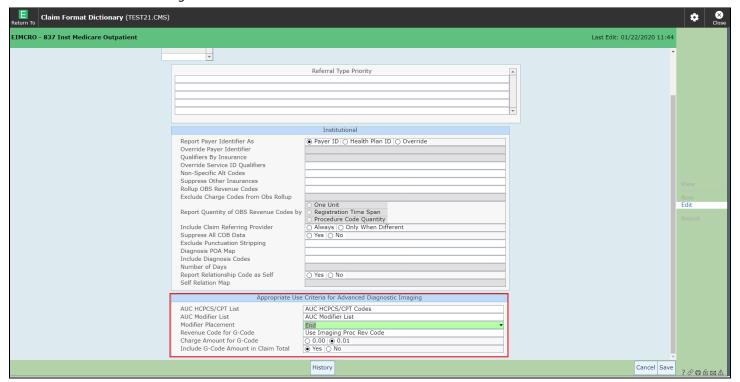
Claim Type Fields

Once the AUC for Imaging Claim Type is available, the following fields are made available:

- AUC HCPCS/CPT List: Define the data list created above that needs to report the AUC modifier and G-Code. The
 G-Code reports on a separate service line. The claim only reports AUC data for HCPCS/CPT codes found in this
 list.
- AUC Modifier List: Define the data list created above of the AUC Modifiers that will be referenced by the claim
 for the AUC modifier placement. The modifier reports on the same line with the imaging service charge. Claim
 programs only report a G-Code line for HCPCS/CPT codes defined in the AUC HCPCS/CPT list when the modifiers
 ME, MF, and MG are reported on the imaging procedure service line.

- **Modifier Placement:** The options include *Beginning* or *End*. This controls where to place the AUC modifiers in relation to any other modifiers on the imaging charge.
- Revenue Code for G-Code (Institutional/UB 04 Only): The options include *Use Imaging Proc Rev Code* or *Use Rev Code ending in 9*.
 - Use Imaging Proc Rev Code: Print the G-Code on a service line using the same Rev code as the imaging procedure code.
 - Use Rev Code ending in 9: Print the G-Code on a service line using a Rev code associated to the imaging
 - o procedure category ending in 9.
- Charge Amount for G-Code: Options include \$0.00 or \$0.01. This controls the dollar amount associated with the G-Code on the claim.
 - Medicare Institutional claims require \$0.01 to report on the service line reporting the G-Code.
- Include G-Code Amount in Claim Total: Options include Yes or No. Yes will add penny amounts to the claim total amount. This is not reflected on the accounts total charges. No will exclude any dollar amount associated with the G-Code from the claim total amount. This should be set depending on if your clearinghouse or MAC wants the penny charge associated with the G-Code line to be included on the claim total charge amount or not.

Financial > Patient Accounting > Dictionaries > Claim > Format



Revenue Cycle: Optional AUC Functionality & Setup

Account Checks: AUC VENDOR NAME

- This check will fail if an AUC G-Code exists from the Data List without an associated Vendor name. (The Data List should only need to include G1011).
- This check can also be used as a Value Check to return the value of the Vendor Name from the AUC Vendor Name query. This may be needed on the 1500-12 claim form.

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- For both the G-Code and Vendor Name queries, the check looks at the AUC Imaging transaction-level queries as defined in the Charge Description Master Parameters.
- This can be used as a UR, Proration, Claim, or Value Check.

ALT MOD REQ QRY

- This check will fail if a charge has both an Alt Code and Modifier from the Data Lists, but no value for the defined Txn Query.
- This check can be used to ensure that an AUC Imaging Charge with modifier ME, MF, or MG has a G-Code.
- This can be used as a UR, Proration, or Claim Check.

TXN REO MOD

- This existing Account Check will fail if a charge transaction is missing a modifier.
- This check can be used to ensure that an AUC Imaging Charge has an AUC modifier.

Claim Output

Once the above setup is completed and claims are generated, the following information will report on claims:

Note: The Ordering Provider's NPI will only generate if the Ordering/Referring Txn Detail requirement is selected for all imaging charges in the Charge Description Master dictionary or for all imaging charge Revenue Codes in the Charge Category dictionary.

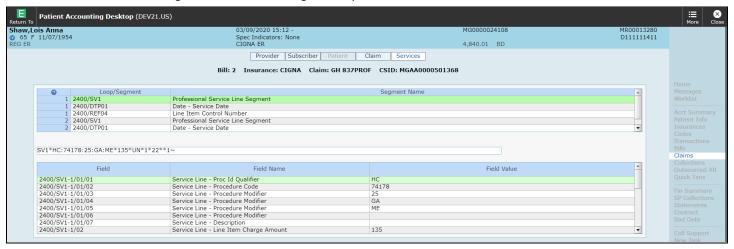
837 Institutional & 837 Professional

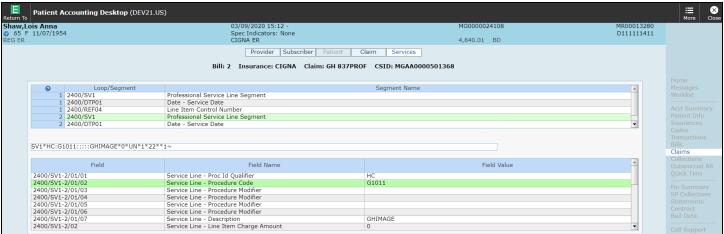
- The Imaging Charge Procedure and Modifier will print on the 2400/SV2 loop and segment.
- The AUC G-Code will print on a separately created 2400/SV2 loop and segment with the G-Code as the Procedure Code, if the imaging charge procedure has a modifier of ME, MF, or MG.
- On an 837 Institutional Claim, the Ordering Provider's NPI number prints in the 2300/K3 segment.
 - AUC: Represents the program.
 - **LX:** Represents the service line of the imaging procedure.
 - O DK: Represents the Ordering Provider's NPI.
- On a 837 Professional Claim, the Ordering Provider's NPI prints in the 2420E/NM1 loop and segment.
- The rest of the information that reports, such as the charge amount and modifier placement, will depend on the settings of the AUC for Imaging Claim Type within the Claim Format.

An example of an 837 Professional Claim with the Imaging Charge Procedure service line and the G-Code service line:

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Financial > Patient Accounting > Patient Accounting Desktop





UB04

- The Imaging Charge Procedure and modifier prints on field 44.
- The AUC G-Code prints on its own line on field 44 if the Imaging Charge Procedure has a modifier of ME, MF, or MG.
- The Vendor Name will print in field 80 if the G-Code is G1011. The field references which service line has the G-Code, followed by a colon and then the vendor name. For example, if G-Code G1011 was on line 3 and the Vendor Name was AgileMD, field 80 would print: 3:G1011:AgileMD.
- The Ordering Provder's NPI prints in field 80. The field references the service line number of the Imaging Procedure followed by a colon, and then the DK qualifier and the NPI number. For example, if the AUC imaging procedure was on line 2 and the Ordering Provider's NPI was 9876543210, field 80 would print: 2:DK9876543210.
- The rest of the information that reports, such as the charge amount and the modifier placement, will depend on the settings of the AUC for Imaging Claim Type within the Claim Format.

1500-12

- The Imaging Charge Procedure prints in field 24.
- The AUC G-Code is created on a separate line in field 24 with the G-Code as the procedure code, if the Imaging Charge Procedure has a modifier of ME, MF, or MG.

• The rest of the information that reports, such as the charge amount and the modifier placement, will depend on the settings of the AUC for Imaging Claim Type within the Claim Format.

MEDITECH Output Formats

• Imaging AUC Deficiency and Utilization Report

Supporting Documentation

CMS.Gov

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM 11268.pdf

Expanse Workflow Guides:

https://customer.meditech.com/en/d/iaucresources/pages/616aucimpguide.htm

Questions

Please contact your MEDITECH Order Management or RCG Claims specialist.

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