CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1699	**Date: August 5, 2016**
	Change Request 9707

SUBJECT: Appropriate Use Criteria for Advanced Imaging – Analysis and Design

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is for all system maintainers to provide input and contribute to developing solutions to implement claims processing edits for the new Medicare appropriate use criteria program.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	**CHAPTER / SECTION / SUBSECTION / TITLE**
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

One Time Notification

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1699	Date: August 5, 2016	Change Request: 9707

SUBJECT: Appropriate Use Criteria for Advanced Imaging – Analysis and Design

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2017

I. GENERAL INFORMATION

A. Background: The Protecting Access to Medicare Act (PAMA) of 2014 section 218(b) established a new program to reduce the inappropriate use of advanced imaging services and increase the rate of appropriate imaging services. Examples of advanced imaging services includes computed tomography, positron emission tomography, nuclear medicine and magnetic resonance imaging. Under this program, at the time a practitioner orders an advanced imaging service for a Medicare beneficiary, he/she will be required to consult a clinical decision support mechanism (CDSM). CDSMs are the electronic portals through which practitioners access appropriate use criteria during the patient workup. The CDSM will provide the ordering practitioner with a determination of whether that order adheres to appropriate use criteria, does not adhere to appropriate use criteria or if there is no appropriate use criteria applicable. This information from the CDSM consultation must be sent from the ordering professional to the furnishing professional and appended to the furnishing professional's Medicare claim. The furnishing professional in these scenarios will be the radiologist that interprets the image. PAMA 218(b) identifies additional information that must be appended to the furnishing practitioner's claim. This includes the national provider identifier of the ordering practitioner and identifying which CDSM was consulted (we foresee multiple CDSMs becoming available). Our overarching goal is to establish claims processing edits that allow for the appropriate claims to be denied or returned to the provider when they fail to contain the new, required information. A white paper with additional information regarding the appropriate use criteria program will be made available upon the effective date of this CR.

B. Policy: This CR does not involve any legislative or regulatory policies.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
9707.1	There shall be 5 (one hour) mandatory calls to be scheduled every two weeks with contractors and the Centers for Medicare & Medicaid Services (CMS) in order to discuss the development of options and recommendations. The calls will be scheduled after August 8, 2016 with specific dates and time to be determined and	X	X			X	X		X	

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
	scheduled by CMS. CMS will prepare an agenda and distribute to call participants 2-3 days in advance of the call. A designated contact list needs to be submitted to the following email within 20 days of the publication of the Analysis CR so that conference calls can be arranged. Please send this information to the email below: JoAnna.Baldwin@cms.hhs.gov									
9707.1.1	Maintainers shall be required on a rotating basis to designate someone to take meeting notes and post minutes in ECHIMP within 2 business days. The rotation will be determined at the time the meetings are scheduled.					X	X		X	
9707.1.2	Maintainers shall be required to use an issues log (attachment 1) to track issues that arise and document related discussion and decisions.					X	X		X	
9707.2	The maintainers with input from contractors shall provide interim recommendations after the third conference call. The recommendations shall address as specifically as possible, options developed and recommendations for implementing claims processing edits that would be required to be included in a forthcoming CMS-developed implementation CR.	X	X			X	X		X	
9707.3	The maintainers shall each provide a Final Report with recommendations within 30 days of the final call. No more than one additional call will be scheduled upon CMS receiving the Final Report.					X	X		X	

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): JoAnna Baldwin, 410-786-7205 or JoAnna.Baldwin@cms.hhs.gov (Coverage and Analysis) , Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage and Analysis Group)

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

ATTACHMENT

EXAMPLE ISSUES LOG

Issue #	Opened By	Date Opened	Issue	Assigned To	Decisions/ Discussion	Date Closed
1	WPS	12/15/14	Effect of participation / assignment on copay and deductible – does this change in any way with the new laws or will we still pay CLFS at 100%?	CMS	Will still pay at 100%. Mandatory assignment will still apply – not affected by proposed rule.	4/14/15