COSMOS
Navigate the Compliance Universe

Compliance Today - July 2021
PAMA compliance and imaging integrity

By Ronnie Sutton

Ronnie Sutton (ronnies@ipro-inc.com) is a Partner and Director of Software Services at iPro Healthcare, located in Calhoun, GA.

- linkedin.com/in/ronnie-sutton/

Ambulatory encounters and patient leakage are two areas that are prone to significant revenue loss for hospitals and health systems. Upcoming compliance mandates related to advanced diagnostic imaging services under the Protecting Access to Medicare Act (PAMA)[1] stand to compound ambulatory revenue threats in the near future. This makes ambulatory order and referral management key targets for process improvements as hospitals seek to meet compliance requirements and protect vital funds.

As patient reengagement in ambulatory services continues to climb after the deferral of many medical procedures during the COVID-19 pandemic, now is an ideal time for healthcare provider organizations to implement measures to guard against revenue threats related to PAMA compliance. This can be achieved by reinforcing workflows associated with ambulatory throughput in order to drive efficiency, reduce the chance of patient harm and denials, and ensure the healthcare organization and its community partners are prepared to comply.

PAMA imaging compliance requirements

Validation of medical necessity to reduce unnecessary costs, poor patient experience, and operational inefficiency is a top priority for hospital leaders. Appropriate use criteria (AUC) programs exist to help ensure that appropriate medical procedures, where the anticipated health benefits exceed potential health risks to the patient, are performed. AUC also play a pivotal role in value-based reporting and reimbursement.

As part of PAMA, the Centers for Medicare & Medicaid Services (CMS) established a new program to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries.[2] Examples of these advanced imaging services include:

- Computed tomography (CT),
- Positron emission tomography (PET),
- Nuclear medicine, and
- Magnetic resonance imaging (MRI).

To comply with PAMA guidelines, physicians ordering exams or studies for Medicare Part B advanced diagnostic imaging must consult AUC through a qualified Clinical Decision Support Mechanism (CDSM), a CMS-approved electronic tool that assists healthcare providers in making the most appropriate treatment decision based on a patient's condition.[3] In order for providers to be reimbursed for these services, associated claims require

Current Procedural Terminology (CPT) codes with appropriate Healthcare Common Procedure Coding System (HCPCS) modifiers and G codes that indicate which qualified CDSM was consulted.

The following HCPCS modifiers have been established for this imaging AUC program, for placement on the same line as the CPT code for the advanced diagnostic imaging service:

- **MA**: The ordering professional is not required to consult a CDSM due to service being rendered to a patient with a suspected or confirmed emergency medical condition.
- **MB**: The ordering professional is not required to consult a CDSM due to the significant hardship exception of insufficient internet access.
- **MC**: The ordering professional is not required to consult a CDSM due to the significant hardship exception of electronic health record or CDSM vendor issues.
- **MD**: The ordering professional is not required to consult a CDSM due to the significant hardship exception of extreme and uncontrollable circumstances.
- **ME**: The order for this service adheres to the AUC in the CDSM consulted by the ordering professional.
- **MF**: The order for this service does not adhere to the AUC in the *MLN Matters* MM11268, related change request number 11268, page 4 of 7 qualified CDSM consulted by the ordering professional.
- **MG**: The order for this service does not have AUC in the CDSM consulted by the ordering professional.
- **MH**: It is unknown if the ordering professional consulted a CDSM for this service as related information was not provided to the furnishing professional or provider.
- **QQ**: The ordering professional consulted a qualified CDSM for this service and the related data were provided to the furnishing professional.

Claims that report HCPCS modifier ME, MF, or MG should additionally indicate a G code on a separate claim line to report which qualified CDSM was consulted. Multiple G codes on a single claim are acceptable. The current list of qualified CDSMs is available on the CMS website.[4]

The above reporting requirements for imaging-related claims are applicable to physician offices, hospital outpatient departments, ambulatory surgery centers (ASC), and independent diagnostic testing facilities reporting under Physician Fee Schedule, Hospital Outpatient Prospective, and ASC Payment Systems.[5] The Educational and Operations Testing Period for the imaging AUC program was extended to run through the end of 2021. During the current preparation period, there are no consequences associated with failure to comply. Beginning on January 1, 2022, however, the ordering professional's consultation with a qualified CDSM must be appended to the claim in order for the claim to be paid.