

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 2040	Date: March 2, 2018
	Change Request 10481

SUBJECT: Appropriate Use Criteria for Advanced Diagnostic Imaging – Voluntary Participation and Reporting Period - Claims Processing Requirements – HCPCS Modifier QQ

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to inform the Medicare Administrative Contractors (MACs) of the appropriate modifier that may be reported on the same claim line as the Current Procedural Terminology (CPT) code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system.

EFFECTIVE DATE: July 1, 2018

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: July 2, 2018

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

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EFFECTIVE DATE: July 1, 2018

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IMPLEMENTATION DATE: July 2, 2018

I. GENERAL INFORMATION

A. Background: 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 rendered to Medicare beneficiaries. Examples of advanced imaging services include 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 qualified 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 professional 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.

A consultation must take place for an applicable imaging service ordered by an ordering professional that would be furnished in an applicable setting and paid under an applicable payment system. Note the applicable setting is where the imaging service is furnished, not the setting where the imaging service is ordered. Applicable settings include physician offices, hospital outpatient departments (including emergency departments), ambulatory surgical centers, and any other provider-led outpatient setting determined appropriate by the Secretary of the Department of Health and Human Services (at this time, no other settings have been identified). Applicable payment systems include the physician fee schedule, the hospital outpatient prospective payment system and the ambulatory surgical center payment system.

When this program is more fully implemented (expected January 1, 2020) consultation with a qualified CDSM will be required and detailed information regarding the ordering professional's consultation must be appended to the furnishing professional's claim. This includes the National Provider Identifier (NPI) of the ordering practitioner and identifying which CDSM was consulted (There are multiple CDSMs available). The Centers for Medicare & Medical Services (CMS) does not have guidance at this time regarding what the claims-based reporting requirements will be in 2020.

Also, when fully implemented this program will include exceptions to consulting CDSMs that 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 and for which payment is made under Part A.

Ultimately, this program will result in identified outlier ordering professionals being subject to prior authorization.

B. Policy:

Regulatory language for this program is in 42 Code of Federal Regulation 414.94 titled Appropriate Use Criteria for Advanced Diagnostic Imaging Services. In the calendar year 2018 Physician Fee Schedule final rule, CMS said this program would begin with a voluntary participation period. During this time, ordering professionals may choose to consult qualified CDSMs and furnishing professionals may choose to report limited consultation information on their Medicare claims. Healthcare Common Procedure Coding System (HCPCS) modifier QQ (effective July 1, 2018) is available for this reporting.

HCPCS Modifier QQ Long Descriptor:

Ordering Professional Consulted A Qualified Clinical Decision Support Mechanism For This Service And The Related Data Was Provided To The Furnishing Professional

The modifier may be reported on the same claim line as the CPT code for an advanced diagnostic imaging service furnished in an applicable setting and paid for under an applicable payment system. The modifier may be reported on both the facility and professional claim.

The modifier may be used when the furnishing professional has an awareness of the result of the ordering professional’s consultation with CDSM for that patient.

II. BUSINESS REQUIREMENTS TABLE

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

Number	Requirement	Responsibility								Other
		A/B MAC			D M E M A C	Shared- System Maintainers				
		A	B	H H H		F I S S	M C S	V M S	C W F	
10481.1	Effective for claims with dates of service on or after July 1, 2018, contractors shall accept the new QQ modifier on the same claim line as any CPT codes that fall within the following ranges identified in Attachment A. NOTE: The QQ modifier may appear on the same claim line as a CPT code that falls outside the range.	X	X							IOCE
10481.2	Until further notice, contractors shall continue to pay claims for services within or outside the CPT code range identified in Attachment A regardless of the presence of HCPCS modifier QQ.	X	X							IOCE

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			D M E M A C	C E D I
		A	B	H H H		
10481.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X	X			

IV. SUPPORTING INFORMATION

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

"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 Group) , Wanda Belle, 410-786-7491 or wanda.belle@cms.hhs.gov (Coverage)

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 A

MRI

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

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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

SPECT

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, 78205, 78206, 78215, 78216, 78226, 78227, 78230, 78231, 78232, 78258, 78261, 78262, 78264, 78265, 78266, 78267, 78268, 78270, 78271, 78272, 78278, 78282, 78290, 78291, 78299, 78300, 78305, 78306, 78315, 78320, 78350, 78351, 78399, 78414, 78428, 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, 78607, 78608, 78609, 78610, 78630, 78635, 78645, 78647, 78650, 78660, 78699, 78700, 78701, 78707, 78708, 78709, 78710, 78725, 78730, 78740, 78761, 78799, 78800, 78801, 78802, 78803, 78804, 78805, 78806, 78807, 78811, 78812, 78813, 78814, 78816, 78816, 78999