



## Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims

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Note: We revised this article on February 20, 2020, to include the listing of CDSMs (page 6) and to update paper billing instruction to direct providers to the NUBC for instructions on reporting the ordering physician NPI (page 2) and special reporting required for the CDSMs using HCPCS G1011 on paper claims (page 3). The article release date was also changed. All other information is the same.

### PROVIDER TYPES AFFECTED

This Special Edition Article is for institutional providers billing Medicare Administrative Contractors (MACs) for services they provide to Medicare beneficiaries.

### PROVIDER ACTION NEEDED

This article (SE20002) provides guidance for processing claims for certain institutional claims that are subject to the Appropriate Use Criteria (AUC) program for advanced diagnostic imaging services. The Centers for Medicare & Medicaid Services (CMS) will begin to accept claims with this information as of January 1, 2020. This is the beginning of the education and operations testing period for the AUC program. While there will not be payment penalties during this period, stakeholders and CMS can use this time to practice reporting and accepting AUC information on claims. The K3 segment will be used to report line level ordering professional information on institutional claims.

For other claims processing information for the AUC program including HCPCS modifiers and codes, please see MLN Matters article MM11268, Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf>. For general information regarding the AUC program please visit <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Appropriate-Use-Criteria-Program/index>.

### Key Points

During CY 2020, CMS expects ordering professionals to begin consulting qualified clinical decision support mechanisms (CDSMs) and providing information to the furnishing practitioners

and providers for reporting on their claims. Situations in which furnishing practitioners and providers do not receive AUC-related information from the ordering professional can be reported by modifier MH. During this phase of the program claims will not be denied for failing to include AUC-related information or for misreporting AUC information on non-imaging claims, but inclusion is encouraged.

### Required Reporting of Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging CDSM G-codes and Modifiers

A modifier (MA-MH) is reported on the same claim line as any Advance Diagnostic Imaging HCPCS code. When a qualified CDSM was consulted, the CDSM HCPCS modifier ME, MF or MG is reported on the Advance Diagnostic Imaging service HCPCS code. Additionally, a separate line with a CDSM G-code is reported.

Each reported CDSM G-code must contain the following line of service information:

- Date of the related Advanced Diagnostic Imaging service
- Nominal charge, e.g., a penny, for institutional claims submitted to the A/B MACs (A).

### Reporting the ordering professional's National Provider Identifier (NPI) on institutional claims

In this Special Edition article, CMS clarifies the method of reporting the ordering professional's National Provider Identifier (NPI) on institutional claims for advanced diagnostic imaging services subject to the AUC program. This information, for institutional claims, will be reported using the K3 segment *in electronic claims. For paper claims, contact the NUBC for billing instructions for reporting the ordering professional's NPI.* When reporting the NPI of the Ordering Professional on institutional *electronic* claims, the K301 will use the following values for each service line that needs an Ordering Professional reported:

- **AUC** represents the program
- **LX** represents the service line followed by the service line number reported in LX01
- **DK** represents the Ordering Professional identifier followed by the Ordering Professional's NPI

If an Ordering Professional NPI is the same for multiple service lines, each service must be reported as a separate service line in the K301. The K301 supports 80 characters, which may allow up to four Ordering Professional NPI iterations in a single K301. Providers may send additional K3 segments as needed but each one must begin with the value of AUC as shown below and demonstrated in the attachments to this article.

#### K3 Examples:

##### Reporting 1 Ordering Professional NPI

K3\*AUC LX1DK111111111~

**Reporting 5 Ordering Professional NPIs**

K3\*AUCLX1DK1111111111LX11DK9999999999LX22DK1111111111LX433DK2222222222~  
 K3\*AUCLX444DK4444444444~

**Qualified CDSM specific HCPCS not yet available**

Providers report the CDSM approved HCPCS G-codes for qualified CDSMs, when available. HCPCS G1011 is designated as “Clinical Decision Support Mechanism, qualified tool not otherwise specified”. When a CDSM has been qualified by CMS but has not received an assigned HCPCS G-codes, providers report HCPCS G1011. *For paper claims, contact the NUBC for billing instructions to report HCPCS G1011. For electronic claims, it is important to remember that the key claim segments should be completed as follows:*

**2400 — SERVICE LINE**

LX01:	Assigned Number	(Depends on claim service line #)
SV201:	Service Line Revenue Code	0359
SV202-1:	Product/Service ID Qualifier	HC
SV202-2:	Product/Service ID	G1011
SV202-7:	Description	CDSM ( <i>insert Name of CDSM</i> )
SV203:	Line Item Charge Amount	.01
SV204:	Unit or Basis for Measurement Code	UN
SV205:	Service Unit Count	1
DTP01:	Date/Time Qualifier	472
DTP02:	Date Time Period Format Qualifier	D8
DTP03:	Date Time Period	20200115

LX\*#~SV2\*0359\*HC:G1011::::CDSM (*insert Name of CDSM*)\*.01\*UN\*1~DTP\*472\*D8\*20200115~

Example if a claim is billed when AgileMD’s CDSM is consulted prior to receiving HCPCS assignment:

**2400 — SERVICE LINE**

LX01:	Assigned Number	(Depends on claim service line #)
SV201:	Service Line Revenue Code	0359
SV202-1:	Product/Service ID Qualifier	HC
SV202-2:	Product/Service ID	G1011

SV202-7:	Description	CDSM AGILEMDS
SV203:	Line Item Charge Amount	.01
SV204:	Unit or Basis for Measurement Code	UN
SV205:	Service Unit Count	1
DTP01:	Date/Time Qualifier	472
DTP02:	Date Time Period Format Qualifier	D8
DTP03:	Date Time Period	20200115

LX\*#~SV2\*0359\*HC:G1011::::CDSM AGILEMDS\*.01\*UN\*1~DTP\*472\*D8\*20200115~

### Multiple consultations of the same CDSM

You can report the qualified CDSM G-codes with the same Revenue code as the Advanced Diagnostic Imaging service or in the Revenue Center that ends in “9” for the Advanced Diagnostic Imaging service.

**For example**, a CDSM G-code for a CT scan order for the head could be reported with either Revenue Code 0351 (CT SCAN/HEAD), which is the same as the imaging service, or Revenue Code 0359 (CT SCAN/OTHER).

A CDSM G-code on a MRI order for the head could be reported with either Revenue Code 0611 (MRI/BRAIN), which is the same as the imaging service, or 0619 (MRT/OTHER).

A) If the multiple consultations of the same CDSM G-code were for the same revenue code series on the claim, the provider has options:

#### Option One

1 line would be reported rolling up all the CDSM queries into 1 Revenue code ending in “9” just 1 time with multiple units.

0351 test 1 unit

0352 test 2 unit

0359 CDSM 2 units

-or use the alternate approach -

#### Option Two

Every specific revenue code that had a CDSM queried, would be reported with the exact same Revenue Code (again, you could see roll-ups if there were 2 separate CPT codes used for the same service where one had with contrast and one had without contrast for the same specific Revenue Code).

0351 test 1 unit

0351 CDSM 1 unit

0352 test 1 unit

0352 CDSM 1 unit

- B) If the multiple consultations were for different revenue code series lines on the claim, there would be at least 1 line for each revenue code series depending on if you use the xxx9 approach for reporting or the specific revenue code approach.

**Option One**

1 line would be reported rolling up all the CDSM queries into 1 Revenue code ending in "9" just 1 unit for each CDSM query.

0351 test 1 unit

0359 CDSM 1 units

0611 test 1 unit

0619 CDSM 1 unit

-or use the alternate approach -

**Option Two**

Every specific revenue code that had a CDSM queried, would be reported with the exact same Revenue Code (again, you could see roll-ups if there were 2 separate CPT codes used for the same service where one had with contrast and one had without contrast for the same specific Revenue Code).

0351 test 1 unit

0351 CDSM 1 units

0611 test 1 unit

0611 CDSM 1 unit

Example of 2 separate CPT codes used for the same service where one had with contrast and one had without contrast for the same specific Revenue Code

0351 test 1 unit with contrast

0351 test 1 unit without contrast

0351 CDSM 2 units

0611 test 1 unit with contrast

0611 test 1 unit without contrast

0611 CDSM 2 units

**Updated G-code Table for Qualified CDSMs**

<b>Mechanism Name</b>	<b>Code</b>
Applied Pathways Clinical Decision Support Mechanism	<b>G1000</b> (Deleted 04/01/2020)
eviCore healthcare's Clinical Decision Support Mechanism	<b>G1001</b>
MedCurrent OrderWise™	<b>G1002</b>
Medicalis Clinical Decision Support Mechanism	<b>G1003</b>
National Decision Support Company CareSelect™	<b>G1004</b>
National Imaging Associates RadMD	<b>G1005</b>
Test Appropriate CDSM	<b>G1006</b>
AIM Specialty Health ProviderPortal®	<b>G1007</b>
Cranberry Peak ezCDS	<b>G1008</b>
Sage Health Management Solutions Inc. RadWise®	<b>G1009</b>

Mechanism Name	Code
Stanson Health's Stanson CDS	<b>G1010</b>
Qualified tool not otherwise specified	<b>G1011</b>
AgileMD's Clinical Decision Support Mechanism	<b>G1012</b> <b>(effective 4/1/2020)</b>
EvidenceCare's Imaging Advisor	<b>G1013</b> <b>(effective 4/1/2020)</b>
InveniQA's Semantic Answers in Medicine™	<b>G1014</b> <b>(effective 4/1/2020)</b>
Reliant Medical Group CDSM	<b>G1015</b> <b>(effective 4/1/2020)</b>
Speed of Care CDSM	<b>G1016</b> <b>(effective 4/1/2020)</b>
HealthHelp's Clinical Decision Support Mechanism	<b>G1017</b> <b>(effective 4/1/2020)</b>

Mechanism Name	Code
INFINX CDSM	<b>G1018</b> (effective 4/1/2020)
LogicNets AUC Solution	<b>G1019</b> (effective 4/1/2020)

### Claim Examples

The attached advanced diagnostic imaging UB-04 claim examples are provided to help you better understand the claims-based reporting concept of the AUC program. This concept is applicable to any of the claims that require AUC program billing to report information about the ordering professional's consultation with AUC.

### ADDITIONAL INFORMATION

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging fact sheet is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AUCDiagnosticImaging-909377.pdf>.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging – Educational and Operations Testing Period - Claims Processing Requirements is available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

Various examples of reporting the K3 segment follow the Document History section of this article.



## DOCUMENT HISTORY

Date of Change	Description
February 20, 2020	We revised this article to include the listing of CDSMs (page 6) and to update paper billing instruction to direct providers to the NUBC for instructions on reporting the ordering physician NPI (page 2) and special reporting required for the CDSMs using HCPCS G1011 on paper claims (page 3). The article release date was also changed.
January 9, 2020	Initial article released.

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Example 1: An Emergency Room Claim – CT is being rendered to a patient with a suspected or confirmed emergency medical condition, for the MRI there is no suspected or confirmed emergency medical condition.

3a PAT. CNTL.#										4 TYPE OF BILL									
b. MED. REC.#										0131									
5. FED.TAX NO.										6. STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020									
10 BIRTHDATE										11 SEX									
13 HR										14 TYPE									
12 DATE										16 D HR									
17 STAT										18									
19										20									
21										22									
23										24									
25										26									
27										28									
29 ACCT STATE										30									
31 OCCURRENCE DATE										32 OCCURRENCE DATE									
33 OCCURRENCE DATE										34 OCCURRENCE DATE									
35 OCCURRENCE DATE										36 OCCURRENCE DATE									
37										38									
39 VALUE CODES										40 VALUE CODES									
a										b									
c										d									
42 REV. CD.										43 DESCRIPTION									
1 0352										CT SCAN/BODY									
2 0450										EMERG ROOM									
3 0612										MR/SPINE									
4 0612										MR/SPINE									
5										6									
7										8									
9										10									
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99										100									

CT Ordering professional is not required to consult a clinical decision support mechanism for CT.

CDSM consulted for MRI and order adheres to the criteria.



**Example 2: An Outpatient Hospital Claim hardship – Ordering Professional had insufficient Internet**

**Hardship Modifier – Ordering Professional had insufficient Internet.**

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0352	CT SCAN/BODY	74261 MB	010120	1	1000.00		
PAGE OF				CREATION DATE	TOTALS		

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE	75 OTHER PROCEDURE	76 ATTENDING	77 OPERATING	78 OTHER

80 REMARKS	81 CC	79 LAST	79 FIRST	79 QUAL



<b>Example 3: An Outpatient Hospital Claim hardship – EHR or CDSM vendor Issues</b>		3a PAT. CNTL # b. MED. REC.#	4 TYPE OF BILL <b>0131</b>												
5. FED.TAX NO.			6. STATEMENT COVERS PERIOD FROM: <b>01012020</b> THROUGH: <b>01012020</b>												
8 PATIENT NAME		9 PATIENT ADDRESS													
10 BIRTHDATE   11 SEX   13 HR   14 TYPE   15 SRC   12 DATE   16 D HR   17 STAT   18   19   20   21   22   23   24   25   26   27   28   29 ACCT STATE   30.															
31 OCCURENCE DATE		32 OCCURENCE DATE		33 OCCURENCE DATE		34 OCCURENCE DATE		35 OCCURENCE SPAN FROM THROUGH		36 OCCURENCE SPAN FROM THROUGH		37			
38					39 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT						
Hardship Modifier – EHR or CDSM vendor Issues.					a		b		c		d				
42 REV. CD.		43 DESCRIPTION		44 ICDPCS/RATES/HPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49	
1 0352		CT SCAN/BODY		74261 MC		010120		1		1000.00					
2															
3															
4															
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21															
22															
23		PAGE OF		CREATION DATE		TOTALS									
A		50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI	
B														57	
C														OTHER	
A		58 INSURED'S NAME		59 P. REL		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.					
B															
C															
A		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME									
B															
C															
A		66		67		68		69		70		71		72	
B		I		J		K		L		M		N		O	
C															
A		69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI		73					
B		c.		d.		e.		76 ATTENDING NPI		QUAL		77 OPERATING NPI		QUAL	
C								LAST		FRST		LAST		FRST	
A		80 REMARKS		81 CC		82		78 OTHER NPI		QUAL		79 OTHER NPI		QUAL	
B				a		b		LAST		FRST		LAST		FRST	
C				c		d		78 OTHER NPI		QUAL		79 OTHER NPI		QUAL	
A				b		c		LAST		FRST		LAST		FRST	
B				d											
C															



**Example 4: An Outpatient Hospital Claimhardship – Ordering Physician in significant hardship exception of extreme and uncontrollable circumstances**

**Hardship Modifier – Ordering Physician in significant hardship exception. If hospital was in disaster area, append Condition Code DR to the hospital claim.**

38 PAT. CNTL #										4 TYPE OF BILL									
b. MED. REC #										0131									
5. FED. TAX NO.										6. STATEMENT COVERS PERIOD FROM THROUGH									
010120										010120									
9 PATIENT NAME										10 PATIENT ADDRESS									
a										b									
10 BIRTHDATE										11 SEX									
13 HR										14 TYPE									
15 SRC										12 DATE									
16 D HR										17 STAT									
18										19									
20										21									
22										23									
24										25									
26										27									
28										29 ADT STATE									
30										31 OCCURRENCE DATE									
32										33									
34										35									
36										37									
38										39									
a										40									
b										41									
c										42									
d										43									
42 REV. CD.										43 DESCRIPTION									
1 0352										CT SCAN/BODY									
44 HCPCS/RATES/HPPS CODE										45 SERV. DATE									
74261 MD										010120									
46 SERV. UNITS										47 TOTAL CHARGES									
1										1000.00									
48 NON-COVERED CHARGES										49									
PAGE										OF									
CREATION DATE										TOTALS									
50 PAYER NAME										51 HEALTH PLAN ID									
A										B									
B										C									
C										52 REL. INFO									
53 ASG BEN										54 PRIOR PAYMENTS									
55 EST. AMOUNT DUE										56 NPI									
57										OTHER									
58 INSURED'S NAME										59 P. REL.									
A										B									
B										C									
C										60 INSURED'S UNIQUE ID									
61 GROUP NAME										62 INSURANCE GROUP NO.									
A										B									
B										C									
63 TREATMENT AUTHORIZATION CODES										64 DOCUMENT CONTROL NUMBER									
A										B									
B										C									
65 EMPLOYER NAME										66 DX									
A										B									
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C										D									
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M										N									
O										P									
Q										67									
68										69 ADMIT DX									
70 PATIENT REASON DX										71 PPS CODE									
72 ECI										73									
74										75									
a										76 ATTENDING NPI									
b										77 OPERATING NPI									
c										78 OTHER NPI									
d										79 OTHER NPI									
80 REMARKS										81 CC									
a										b									
b										c									
c										d									
d										e									

UB-04 CMS-1450

APPROVED OMB NO. 0938-0997

NUBC™ National Uniform

THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Billing Committee LIC3810506

1		2		3a PAT. CNTL # b. MED. REC.# 5. FED.TAX NO.				4 TYPE OF BILL 0131																			
8 PATIENT NAME		a		9 PATIENT ADDRESS		a		6. STATEMENT COVERS PERIOD FROM 01012020		THROUGH 01012020																	
10 BIRTHDATE	11 SEX	13 HR. ADMISSION TYPE		14 SRC	12 DATE	16 D HR	17 STAT	CONDITION CODES			18	19	20	21	22	23	24	25	26	27	28	29 ACCT STATE	30				
31 OCCURENCE DATE		32 OCCURENCE DATE		33 OCCURENCE DATE		34 OCCURENCE DATE		35 OCCURENCE SPAN FROM THROUGH		36 OCCURENCE SPAN FROM THROUGH		37		38 VALUE CODES CODE AMOUNT		40 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT		39		42		43			
42 REV. CD.		43 DESCRIPTION		44 ICDPCS/RATES/HPPS CODE		45 SERV. DATE		46 SERV. UNITS		47 TOTAL CHARGES		48 NON-COVERED CHARGES		49		a		b		c		d					
1	0352	CT SCAN/BODY		74261 MH		010120		1		1000.00																	
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50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI															
A												57															
B												OTHER															
C												PRV ID															
58 INSURED'S NAME		59 P. REL.		60 INSURED'S UNIQUE ID		61 GROUP NAME		62 INSURANCE GROUP NO.		A		B															
A										C		C															
B																											
C																											
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME		A		B																			
A						C		C																			
B																											
C																											
66 67		A		B		C		D		E		F		G		H		68									
I		J		K		L		M		N		O		P		Q											
69 ADMIT DX		70 PATIENT REASON DX		a.		b.		c.		71 PPS CODE		72 ECI		73													
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 OPERATING NPI		78 OTHER NPI		QUAL		LAST		FRST													
c.		d.		e.		79		80		81		82		83													
80 REMARKS		81 CC		a.		b.		c.		d.		79 OTHER NPI		77 OTHER NPI		78 OTHER NPI											
												LAST		FRST													
												LAST		FRST													
												LAST		FRST													
												LAST		FRST													

Unknown Modifier – CDSM not provided with order



**Example 6: An Outpatient Hospital Claim— CDSM consulted and order adheres**

4 TYPE OF BILL: 0131

6 STATEMENT COVERS PERIOD FROM: 01012020 THROUGH: 01012020

38 CDSM Adherence Modifier— CDSM consulted and order adheres

42 REV. CD.	43 DESCRIPTION	44 ICDPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0352	CT SCAN/BODY	74261 ME	010120	1	1000.00		
0359	CT SCAN/OTHER	G10xx	010120	1	.01		

50 PAYER NAME, 51 HEALTH PLAN ID, 52 REL INFO, 53 ASG BEN, 54 PRIOR PAYMENTS, 55 EST. AMOUNT DUE, 56 NPI, 57 OTHER, 58 INSURED'S NAME, 59 P. REL, 60 INSURED'S UNIQUE ID, 61 GROUP NAME, 62 INSURANCE GROUP NO., 63 TREATMENT AUTHORIZATION CODES, 64 DOCUMENT CONTROL NUMBER, 65 EMPLOYER NAME, 66 ICD9-CM, 67 A, B, C, D, E, F, G, H, 68 I, J, K, L, M, N, O, P, Q, 69 ADMIT DX, 70 PATIENT REASON DX, 71 PPS CODE, 72 ECI, 73, 74 PRINCIPAL PROCEDURE, 75 OTHER PROCEDURE, 76 ATTENDING, 77 OPERATING, 78 OTHER, 79 OTHER, 80 REMARKS, 81 CC



1		2		3		4	
		<b>Example 7: An Outpatient Hospital Claim—CDSM consulted and order does not adhere</b>		3a PAT. CNTRL # b. MED. REC.#		4 TYPE OF BILL <b>0131</b>	
8 PATIENT NAME		9 PATIENT ADDRESS		5. FED.TAX NO.		6. STATEMENT COVERS PERIOD FROM <b>01012020</b> THROUGH <b>01012020</b>	
10 BIRTHDATE	11 SEX	13 HR	14 TYPE	15 SRC	12 DATE	16 D HR	17 STAT
CONDITION CODES							
31 OCCURENCE CODE	32 OCCURENCE DATE	33 OCCURENCE CODE	34 OCCURENCE DATE	35 OCCURENCE SPAN FROM	36 OCCURENCE SPAN THROUGH	37	
38				39 VALUE CODES	40 VALUE CODES	41 VALUE CODES	
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> <b>CDSM Non-Adherence Modifier – CDSM consulted and order does not adhere</b> </div>				a	b	c	
				b			
				c			
				d			
42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	<b>0352 CT SCAN/BODY</b>	<b>74261 MF</b>	<b>010120</b>	<b>1</b>	<b>1000.00</b>		
2	<b>0359 CT SCAN/OTHER</b>	<b>G10xx</b>	<b>010120</b>	<b>1</b>	<b>.01</b>		
23		CREATION DATE		TOTALS			
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57	
58 INSURED'S NAME		59 P. REL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
62 INSURANCE GROUP NO.		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
66		67		68		69	
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74 PRINCIPAL PROCEDURE		75 OTHER PROCEDURE		76 ATTENDING NPI		77 OPERATING NPI	
78 OTHER NPI		79 OTHER NPI		80		81	
80 REMARKS		81CC		82		83	



**Example 8: An Outpatient Hospital Claim— CDSM consulted but no AUC for service**

3a PAT. CNTRL #  
b. MED. REC.#  
5. FED.TAX NO.  
6. STATEMENT COVERS PERIOD FROM: 01012020 THROUGH: 01012020  
4. TYPE OF BILL: 0131

8 PATIENT NAME a  
9 PATIENT ADDRESS a  
b  
c  
d  
e

10 BIRTHDATE 11 SEX 13 HR 14 TYPE 15 SRC 12 DATE 16 D HR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30

31 OCCURENCE DATE 32 OCCURENCE DATE 33 OCCURENCE DATE 34 OCCURENCE DATE 35 OCCURENCE SPAN FROM THROUGH 36 OCCURENCE SPAN FROM THROUGH 37

38

**CDSM No AUC for service Modifier – CDSM consulted but no AUC for service**

39 VALUE CODES AMOUNT 40 VALUE CODES AMOUNT 41 VALUE CODES AMOUNT  
a  
b  
c  
d

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0352	CT SCAN/BODY	74261 MG	010120	1	1000.00		1
2 0359	CT SCAN/OTHER	G10xx	010120	1	.01		2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23	PAGE OF	CREATION DATE	TOTALS				23

50 PAYER NAME 51 HEALTH PLAN ID 52 REL INFO 53 ASG BEN 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56 NPI 57  
A B C OTHER  
C PRIV ID

58 INSURED'S NAME 59 P. REL 60 INSURED'S UNIQUE ID 61 GROUP NAME 62 INSURANCE GROUP NO.  
A B C

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME  
A B C

66 67 A B C D E F G H I J K L M N O P Q  
68

69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI 73  
74 PRINCIPAL PROCEDURE DATE a. CODE OTHER PROCEDURE DATE CODE OTHER PROCEDURE DATE 75  
c. OTHER PROCEDURE DATE d. OTHER PROCEDURE DATE e. OTHER PROCEDURE DATE  
76 ATTENDING NPI QUAL LAST FIRST  
77 OPERATING NPI QUAL LAST FIRST  
78 OTHER NPI QUAL LAST FIRST

80 REMARKS 81 CC a b c d



**Example 9: An Outpatient Hospital Claim— Multiple services ordered same Ordering Provider, Same CDSM tool**

**CDSM Modifier – Multiple services ordered same Ordering Provider, Same CDSM**

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0351	CT SCAN/HEAD	70450 ME	010120	1	1000.00		
0352	CT SCAN/BODY	74261 ME	010120	1	1000.00		
0359	CT SCAN/OTHER	G10xx	010120	2	.02		

PAGE 1 OF 1      CREATION DATE      TOTALS

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI

58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME

67	A	B	C	D	E	F	G	H

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73

74	75	76 ATTENDING	77 OPERATING	78 OTHER

80 REMARKS	81 CC	78 OTHER



1		2		3		4	
		<b>Example 10: An Outpatient Hospital Claim— Multiple services ordered same Ordering Provider, different CDSM</b>		3a PAT. CNTRL # b. MED. REC.#		4 TYPE OF BILL <b>0131</b>	
8 PATIENT NAME		9 PATIENT ADDRESS		5. FED.TAX NO.		6. STATEMENT COVERS PERIOD FROM THROUGH	
a		a				7 <b>01012020 01012020</b>	
10 BIRTHDATE		11 SEX		13 HR		14 TYPE	
12 DATE		16 D HR		17 STAT		18	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
35 OCCURRENCE SPAN FROM THROUGH		36 OCCURRENCE SPAN FROM THROUGH		37			
38		39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
		a		b		c	
		b		c		d	
		c		d			
		d					
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATES/HPPS CODE		45 SERV. DATE	
1		0351 CT SCAN/HEAD		70450 ME		010120	
2		0359 CT SCAN/OTHER		G10xb		010120	
3		0612 MRI/SPINE		72148 ME		010120	
4		0619 MRT/OTHER		G10xa		010120	
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		PAGE OF		CREATION DATE		TOTALS	
50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN	
A							
B							
C							
54 PRIOR PAYMENTS		55 EST. AMOUNT DUE		56 NPI		57	
						OTHER	
						PRV ID	
58 INSURED'S NAME		59 P. REL		60 INSURED'S UNIQUE ID		61 GROUP NAME	
A							
B							
C							
62 INSURANCE GROUP NO.							
63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME			
A							
B							
C							
66		67		68		69	
A		B		C		D	
E		F		G		H	
I		J		K		L	
M		N		O		P	
Q							
69 ADMIT DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
a		b		c		d	
74 PRINCIPAL PROCEDURE CODE		75 OTHER PROCEDURE CODE		76 ATTENDING NPI		77 OPERATING NPI	
DATE		DATE		QUAL		QUAL	
				LAST		LAST	
				FIRST		FIRST	
78 OTHER NPI		79 OTHER NPI		80 OTHER NPI		81 OTHER NPI	
a		b		c		d	
LAST		LAST		LAST		LAST	
FIRST		FIRST		FIRST		FIRST	
QUAL		QUAL		QUAL		QUAL	
80 REMARKS		81 CC		82		83	
		a		b		c	
		b		c		d	
		c		d			
		d					

**CDSM Modifier – Multiple services ordered same Ordering Provider, different CDSM.**



<b>Example 11: An Outpatient Hospital Claim – Multiple services ordered different Ordering Provider, different CDSMs</b>										3a PAT. CNTRL # 5. MED. REC.# 5. FED.TAX NO.	4. TYPE OF BILL <b>0131</b>
8 PATIENT NAME a 9 PATIENT ADDRESS a										6. STATEMENT COVERS PERIOD FROM: <b>01012020</b> THROUGH: <b>01012020</b>	
10 BIRTHDATE 11 SEX 13 HR 14 TYPE 15 SRC 12 DATE 16 D HR 17 STAT 18 19 20 21 22 23 24 25 26 27 28 29 ACCT STATE 30											
31 OCCURRENCE DATE 32 OCCURRENCE DATE 33 OCCURRENCE DATE 34 OCCURRENCE DATE 35 OCCURRENCE SPAN FROM THROUGH 36 OCCURRENCE SPAN FROM THROUGH 37											
38										39 VALUE CODES AMOUNT 40 VALUE CODES AMOUNT 41 VALUE CODES AMOUNT	
<b>CDSM Modifier – Multiple services ordered different Ordering Provider, different CDSMs</b>										a b c d	
42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/HPPS CODE		45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49			
1 0351	CT SCAN/HEAD	70450 ME		010120	1	1000.00					
2 0359	CT SCAN/OTHER	G10xa		010120	1	.01					
3 0612	MR/SPINE	72148 ME		010120	1	1500.00					
4 0619	MRT/OTHER	G10xb		010120	1	.01					
23 PAGE OF CREATION DATE TOTALS											
50 PAYER NAME 51 HEALTH PLAN ID 52 REL INFO 53 ASG BEN 54 PRIOR PAYMENTS 55 EST. AMOUNT DUE 56 NPI										57	
58 INSURED'S NAME 59 P. REL 60 INSURED'S UNIQUE ID 61 GROUP NAME 62 INSURANCE GROUP NO.										OTHER	
63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME										PRV ID	
66 67 A B C D E F G H I J K L M N O P Q										68	
69 ADMIT DX 70 PATIENT REASON DX a b c 71 PPS CODE 72 ECI 73											
74 PRINCIPAL PROCEDURE DATE a. CODE OTHER PROCEDURE DATE CODE OTHER PROCEDURE DATE 75										76 ATTENDING NPI QUAL	
c. OTHER PROCEDURE DATE d. OTHER PROCEDURE DATE e. OTHER PROCEDURE DATE										LAST FIRST	
80 REMARKS 81CC a b c d										77 OPERATING NPI QUAL	
										LAST FIRST	
										78 OTHER NPI QUAL	
										LAST FIRST	
										78 OTHER NPI QUAL	
										LAST FIRST	

