



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

MLN Matters Number: SE20002

Related Change Request (CR) Number: N/A

Related CR Release Date: January 9, 2020

Effective Date: N/A

Related CR Transmittal Number: N/A

Implementation Date: January 1, 2020

### PROVIDER TYPES AFFECTED

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

### PROVIDER ACTION NEEDED

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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

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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. When reporting the NPI of the Ordering Professional on institutional 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\*AUCLX1DK111111111~

##### Reporting 5 Ordering Professional NPIs

K3\*AUCLX1DK111111111LX11DK999999999LX22DK111111111LX433DK222222222~

K3\*AUCLX444DK444444444~

**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. 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

## 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
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.**

39 PAT. CONT. #	4 TYPE OF BILL
40 MED. RES. #	0131
5. FED. TAX NO.	6. STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020

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

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/PPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1 0352	DK9876543210	74261 MA	010120	1	1000.00		1
2 0450	EMERG ROOM	99285	010120	1	2000.00		2
3 0612	DK0123456789	72148 ME	010120	1	1500.00		3
4 0612	MRI/SPINE	G10xx	010120	1	.01		4

**CDSM consulted for MRI and order adheres to the criteria.**

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

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



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

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

3a PAT. CNTL.#	4 TYPE OF BILL																			
5. MED. REC.#	0131																			
5. FED.TAX NO.	6. STATEMENT COVERS PERIOD FROM: 01012020 THROUGH: 01012020																			
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 CODE	32 OCCURENCE DATE	33 OCCURENCE CODE	34 OCCURENCE DATE	35 OCCURENCE CODE	36 OCCURENCE DATE	37	38	39 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	42	43	44	45	46	47	48	49		
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	DK9876543210	74261 MB	010120	1	1000.00															
PAGE ____ OF ____					CREATION DATE	TOTALS														
60 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																				
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 DX	67	A	B	C	D	E	F	G	H	68										
69 ADMIT REASON DX	70 PATIENT REASON DX	a	b	c	71 PPS CODE	72 ECI	73													
74	75	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80	81													
74	75	76 ATTENDING NPI	77 OPERATING NPI	78 OTHER NPI	79 OTHER NPI	80	81													
80 REMARKS	81 CC	a	b	c	d	82	83													

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1		2		3a PAT. CNTRL #		4 TYPE OF BILL	
		<b>Example 3: An Outpatient Hospital Claim hardship – EHR or CDSM vendor Issues</b>				<b>0131</b>	
				5. FED.TAX NO.		6. STATEMENT COVERS PERIOD FROM THROUGH	
						01012020 01012020	
8 PATIENT NAME		9 PATIENT ADDRESS					
a		b		c		d	
10 BIRTHDATE		11 SEX		13 HR		14 TYPE	
12 DATE		16 DHR		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 CODE		36 CODE		37 CODE		38 CODE	
39 VALUE CODES AMOUNT		40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT		42	
a		b		c		d	
43 DESCRIPTION		44 HCPCS/RATES/PPS CODE		45 SERV. DATE		46 SERV. UNITS	
0352 DK9876543210		74261 MC		010120		1	
47 TOTAL CHARGES		48 NON-COVERED CHARGES		49			
1000.00							
PAGE OF		CREATION DATE		TOTALS			
A		B		C		D	
51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE		56 NPI		57		58	
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	
A		B		C		D	
67		A		B		C	
I		J		K		L	
M		N		O		P	
Q		R		S		T	
69 ADMIT DATE		70 PATIENT REASON/DX		71 PPS CODE		72 ECI	
73		74		75		76	
77 OTHER		78 OTHER		79 OTHER		80	
a		b		c		d	
81 CC		82		83		84	
a		b		c		d	
85		86		87		88	
89		90		91		92	
93		94		95		96	
97		98		99		100	

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

3a PAT. CNTL #		4 TYPE OF BILL	
b. MED. REC.#		0131	
5. FED. TAX NO.		6. STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020	
8 PATIENT NAME		9 PATIENT ADDRESS	
10 BIRTHDATE		11 SEX	
12 DATE		13 STAT	
14 TYPE		15 SRC	
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 SPAN FROM THROUGH		37 OCCURRENCE SPAN FROM THROUGH	
38		39 VALUE CODES AMOUNT	
40 VALUE CODES AMOUNT		41 VALUE CODES AMOUNT	
42 REV. CD.		43 DESCRIPTION	
0352		DK9876543210	
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	
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 DX		67	
68		69	
70 PATIENT REASON DX		71 PPS CODE	
72 ECI		73	
74 PRINCIPAL PROCEDURE CODE DATE		75 OTHER PROCEDURE CODE DATE	
76 ATTENDING NPI		77 OPERATING NPI	
78 OTHER NPI		79 OTHER NPI	
80 REMARKS		81C	

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

1		2		3a PAT. CNTRL #		4 TYPE OF BILL	
		<b>Example 5: An Outpatient Hospital Claim— Unknown, CDSM not provided with order</b>		5. FED. TAX NO.		6. STATEMENT COVERS PERIOD FROM THROUGH	
						0131	
8 PATIENT NAME		9 PATIENT ADDRESS				7	
a		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		13	
14		15		16		17	
18		19		20		21	
22		23		24		25	
26		27		28		29	
30		31		32		33	
34		35		36		37	
38		39		40		41	
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 DK9876543210		74261 MH		010120	
2						1	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23		PAGE OF		CREATION DATE		TOTALS	
A		B		C		D	
51 HEALTH PLAN ID		52 REL INFO		53 ASG BEN		54 PRIOR PAYMENTS	
55 EST. AMOUNT DUE		56 NPI		57		58	
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	
A		B		C		D	
67		A		B		C	
68		D		E		F	
69		G		H		I	
70		J		K		L	
71		M		N		O	
72		P		Q		R	
73		S		T		U	
74		75		76		77	
78		79		80		81	
82		83		84		85	
86		87		88		89	
90		91		92		93	
94		95		96		97	
98		99		00		01	

Uknown Modifier – CDSM not provided with order



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

3a PAT. CNTL.#  
5. MED. REC.#  
5. FED. TAX NO.

4 TYPE OF BILL  
**0131**

6. STATEMENT COVERS PERIOD  
FROM: **01012020** THROUGH: **01012020**

8 PATIENT NAME a  
9 PATIENT ADDRESS a

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

38

**CDSM Adherence Modifier – CDSM consulted and order adheres**

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	DK9876543210	74261 ME	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 PRV 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 71 PPS CODE 72 ECI 73  
a b c

74	75	76	77	78	79
PRINCIPAL PROCEDURE CODE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	OTHER PROCEDURE CODE	DATE
a	b	c	d	e	

80 REMARKS 81 CC a b c d  
76 ATTENDING NPI QUAL LAST FIRST  
77 OPERATING NPI QUAL LAST FIRST  
78 OTHER NPI QUAL LAST FIRST

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**Example 7: An Outpatient Hospital Claim- CDSM consulted and order does not adhere**

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

8 PATIENT NAME a 9 PATIENT ADDRESS a

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

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

38

**CDSM Non-Adherence Modifier – CDSM consulted and order does not adhere**

39 VALUE CODES CODE AMOUNT 40 VALUE CODES CODE AMOUNT 41 VALUE CODES CODE AMOUNT

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	DK9876543210	74261 MF	010120	1	1000.00		
2	0359	CT SCAN/OTHER	G10xx	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  
 A B C OTHER PRV ID A B C

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

63 TREATMENT AUTHORIZATION CODES 64 DOCUMENT CONTROL NUMBER 65 EMPLOYER NAME A B C 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 CODE DATE a OTHER PROCEDURE CODE DATE b OTHER PROCEDURE CODE DATE c OTHER PROCEDURE CODE DATE d OTHER PROCEDURE CODE DATE e OTHER PROCEDURE CODE DATE f

75 ATTENDING NPI QUAL LAST FIRST 76 OPERATING NPI QUAL LAST FIRST 77 OTHER NPI QUAL LAST FIRST 78 OTHER NPI QUAL LAST FIRST

80 REMARKS 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC™ National Uniform Billing Committee LIC3810506 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.



1		2		3a PAT. CNTY. #		4 TYPE OF BILL	
		<b>Example 8: An Outpatient Hospital Claim— CDSM consulted but no AUC for service</b>		E. MED. REC.#		0131	
8 PATIENT NAME		a		5. FED. TAX NO.		6. STATEMENT COVERS PERIOD FROM THROUGH	
				01012020		01012020	
10 BIRTHDATE		11 SEX		13 HR		14 TYPE	
15 OCCURRENCE DATE		16 DHR		17 STAT		18	
31 OCCURRENCE DATE		32 OCCURRENCE DATE		33 OCCURRENCE DATE		34 OCCURRENCE DATE	
38		39 VALUE CODES		40 VALUE CODES		41 VALUE CODES	
CDSM No AUC for service Modifier – CDSM consulted but no AUC for service		a		b		c	
42 REV. CD.		43 DESCRIPTION		44 HCPCS/RATES/PPPS CODE		45 SERV. DATE	
1		0352 DK9876543210		74261 MG		010120	
2		0359 CT SCAN/OTHER		G10xx		010120	
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
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17							
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19							
20							
21							
22							
23		PAGE OF		CREATION DATE		TOTALS	
A		50 PAYER NAME		51 HEALTH PLAN ID		52 REL INFO	
B							
C							
A		56 INSURED'S NAME		59 P. REL.		60 INSURED'S UNIQUE ID	
B							
C							
A		63 TREATMENT AUTHORIZATION CODES		64 DOCUMENT CONTROL NUMBER		65 EMPLOYER NAME	
B							
C							
67		A		B		C	
I		J		K		L	
69 ADMIT REASON DX		70 PATIENT REASON DX		71 PPS CODE		72 ECI	
74		75		76 ATTENDING NPI		77 OPERATING NPI	
c.		d.		LAST		FIRST	
80 REMARKS		81CC		78 OTHER NPI		79 OTHER NPI	
		a		LAST		FIRST	
		b					
		c					
		d		LAST		FIRST	

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

3a PAT. CNTL.# 4 TYPE OF BILL 0131  
 5. FED.TAX NO. 6. STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020

8 PATIENT NAME a 9 PATIENT ADDRESS 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 Modifier – Multiple services ordered same Ordering Provider, Same CDSM**

39 VALUE CODES AMOUNT 40 VALUE CODES AMOUNT 41 VALUE CODES AMOUNT

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	DK9876543210	70450 ME	010120	1	1000.00		
0352	DK9876543210	74261 ME	010120	1	1000.00		
0359	CT SCAN/OTHER	G10xx	010120	2	.02		

23 PAGE OF CREATION DATE TOTALS

60 PAYER NAME 61 HEALTH PLAN ID 62 REL INFO 63 ASG BEN 64 PRIOR PAYMENTS 65 EST. AMOUNT DUE 66 NPI 67

68 INSURED'S NAME 69 P. REL 70 INSURED'S UNIQUE ID 71 GROUP NAME 72 INSURANCE GROUP NO.

73 TREATMENT AUTHORIZATION CODES 74 DOCUMENT CONTROL NUMBER 75 EMPLOYER NAME

76 67 A B C D E F G H 76  
 I J K L M N O P Q

77 ADMIT REASON DX 78 PATIENT a b c 79 PPS CODE 80 ECI 81

82 OTHER PROCEDURE DATE CODE OTHER PROCEDURE DATE CODE OTHER PROCEDURE DATE CODE OTHER PROCEDURE DATE CODE

83 ATTENDING NPI QUAL LAST FIRST

84 OPERATING NPI QUAL LAST FIRST

85 OTHER NPI QUAL LAST FIRST

86 REMARKS 87 CC a b c d

88 ATTENDING NPI QUAL LAST FIRST

89 OTHER NPI QUAL LAST FIRST

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**Example 10: An Outpatient Hospital Claim- Multiple services ordered same Ordering Provider, different CDSM**

4 TYPE OF BILL: **0131**

6. STATEMENT COVERS PERIOD FROM: **01012020** THROUGH: **01012020**

8 PATIENT NAME: a  
9 PATIENT ADDRESS: a

10 BIRTHDATE: b  
11 SEX: c  
13 HR: d  
14 TYPE: e  
15 SRC: f  
16 DHR: g  
17 STAT: h  
18: i  
19: j  
20: k  
21: l  
22: m  
23: n  
24: o  
25: p  
26: q  
27: r  
28: s  
29 ACCT STATE: t

31 OCCURRENCE CODE: u  
32 OCCURRENCE DATE: v  
33 OCCURRENCE CODE: w  
34 OCCURRENCE DATE: x  
35 OCCURRENCE SPAN FROM: y  
36 OCCURRENCE SPAN THROUGH: z  
37: aa

38: ab  
39 VALUE CODES CODE: ac  
40 VALUE CODES AMOUNT: ad  
41 VALUE CODES CODE: ae  
42 VALUE CODES AMOUNT: af

**CDSM Modifier – Multiple services ordered same Ordering Provider, different 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	DK9876543210	70450 ME	010120	1	1000.00		1
0359	CT SCAN/OTHER	G10xb	010120	1	.01		2
0612	DK9876543210	72148 ME	010120	1	1500.00		3
0619	MRT/OTHER	G10xa	010120	1	.01		4

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 OTHER PRV ID

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

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

74 PRINCIPAL PROCEDURE CODE DATE 75 OTHER PROCEDURE CODE DATE 76 ATTENDING NPI QUAL LAST FIRST 77 OPERATING NPI QUAL LAST FIRST 78 OTHER NPI QUAL LAST FIRST

80 REMARKS 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 NUBC™ National Uniform Billing Committee LIC3810506 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.





**Example 11: An Outpatient Hospital Claim – Multiple services ordered different Ordering Provider, different CDSMs**

**CDSM Modifier – Multiple services ordered different Ordering Provider, different CDSMs**

42 REV. CD.	43 DESCRIPTION	44 HCPCS/RATES/PPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0351	DK9876543210	70450 ME	010120	1	1000.00		1
0359	CT SCAN/OTHER	G10xa	010120	1	.01		2
0612	DK0123456789	72148 ME	010120	1	1500.00		3
0619	MRT/OTHER	G10xb	010120	1	.01		4

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