ahra
the association for medical imaging management

September 6, 2016

The Honorable Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–1656–P
P.O. Box 8013
Baltimore, MD 21244–1850

Dear Administrator Slavitt:

On behalf of AHRA, we are pleased to submit the following comments on the 2017 Medicare Hospital Outpatient Prospective Payment System (OPPS) proposed rule (CMS-1656-P). AHRA: The Association for Medical Imaging Management is the professional organization representing over 5,000 members at all levels of management at 1,800 hospital imaging departments, freestanding imaging centers, and group practices. Collectively, AHRA members employ or supervise over 100,000 radiologic technologists, managers, and administrative staff.

Our comments are focused on three issues:

1-Payment Modifier for X-ray Films
2-Implementation of Section 603 of the Bipartisan Budget Act of 2015
3-Proposed Ambulatory Payment Consolidation

1-Payment Modifier for X-ray Films

While we recognize that CMS must follow the statutory requirements in the Consolidated Appropriations Act of 2016, we remain disappointed that this policy decision was made without any consideration of the operational and financial burden on hospitals, both acute care and critical access, to implement the capital equipment, training, information systems programming, billing and audit processes. The rather quick announcement and required timeline is disruptive to the strong installed base of CR systems long regarded as digital systems.

AHRA seeks two points of clarification from CMS on the proposed modifier code to identify X-rays taken using film.

First, what modifier code is CMS proposing for use in the OPPS?

Second, CMS should clarify how this modifier applies to Critical Access Hospitals. Since CAHs do not bill through the PFS or HOPPS, it would seem that neither this TBD modifier, nor the CT modifier for non-XR-29-compliant CT machines would be relevant to CAHs. There remains confusion in the imaging and CAH communities on this point.

2-Implementation of Section 603 of the Bipartisan Budget Act of 2015

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AHRA asserts that several of the proposed provisions limiting the exception to Section 603 regarding the "Applicability of Exception at Section 1833(t)(21)(B)(ii) of the Act" go well beyond Congressional intent, will have undesirable consequences if adopted, and should be revised in the final rule.

CMS argues in the proposed rule that the "statutory language refers to such departments…as they existed at the time of enactment of Pub. L. 114-74." We strongly disagree. There is nothing in the legislative history nor any comments made contemporaneous to enactment of PL 114-74 that supports this conclusion.

As currently proposed, excepted off-campus Provider-Based Departments (PBDs) may not move nor expand services to a new "clinical family" and retain OPPS rates for those new services. The rationale provided is that "these proposals are made in accordance with our belief that section 603…is intended to curb the practice of hospital acquisition of physician practices that then result in receiving additional Medicare payment for similar services."

We concur that the statute clearly is intended to limit the **future** ability of hospitals to acquire physician practices and convert them to off-campus hospital outpatient departments and obtain the higher reimbursement associated with this conversion. However, prohibiting PBDs that existed at the time of enactment of PL 114-74 from moving or adding new services is completely contrary to the clear and unambiguous meaning and intent of the statute.

The statutory language is quite clear in terms of the application of the exception. It states:

> "For purposes of paragraph (1)(B)(v) and this paragraph, the term `off-campus outpatient department of a provider' shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to the date of the enactment of this paragraph."

Had Congress intended Section 603 to prohibit existing PBDs from moving or offering new services, it could have written the statute in such a way that such actions were prohibited.

There are very legitimate reasons why Congress did not draft the statute as CMS is interpreting and we do not believe CMS is properly considering some of the negative side effects Congress foresaw when it wrote the language for the Section 603 exception.

For example, if CMS restricts these entities to their current address, they do not have the freedom of movement that tenants, and subsequently patients, deserve. More importantly, they lose any negotiating power they may have had with their landlord when it comes to the rent being charged for the space they occupy. We do not agree that this was what Congress intended when it enacted PL 114-74.

This type of situation is not without precedent.

AHRA is aware of similar circumstances in the Medicare program where CMS is prohibiting other Medicare certified facilities from retaining a similar so-called "grandfather" protection if

the facility moves from their current location. Several of these facilities were taken advantage of by their landlords who either imposed extraordinary rent increases or refused to maintain the property. Landlords who learn that the Medicare certified facility would lose their protected status if the facility were to move, can abuse this knowledge during lease negotiation.

Furthermore, CMS should not finalize this rule as proposed because doing so would reduce access to care. By limiting these excepted off-campus PBDs to the set of services or "clinical families" they were performing on the date of enactment of PL 114-74, CMS is unnecessarily restricting the PBDs Congress explicitly exempted. Instead of providing the full suite of services that the PBD could provide, excepted PBDs will likely refer patients to a different site that can offer services at the OPPS rate.

Specifically with regard to imaging, which has seen a considerable decline in reimbursement under the physician fee schedule (PFS) since 2004, off-campus PBDs offering "advanced" imaging will be unlikely to expand into the "minor" imaging clinical families because payment for these "new" services under the PFS will be insufficient to cover the cost of these services. Similarly off-campus OPDs that were offering "minor" imaging on the date of enactment of PL 114-74 will find it financially unattractive to offer "advanced" imaging using the PFS system.

This is unfortunate because imaging is a diagnostic tool that can be used to improve the effectiveness of the entire scope of services performed at the PBD. Requiring patients to travel to a different location to obtain a service that could have been made available at an existing off-campus OPD will create a hardship for patients and increase the likelihood that the patient may not obtain the necessary service.

As a result of the multiple rounds of cuts in the PFS to both the Technical (TC) and Professional (PC) parts of imaging since 2004, many freestanding imaging centers and IDTFs have had to close or become off-campus PBDs to survive. While we understand Congress' desire to deliver cost-effective care and the statutory restraints imposed on CMS by Congress, we are concerned that access to imaging services may be further reduced because the only payment schedule available henceforth will be the PFS.

We would recommend CMS adopt an interpretation consistent with the clear and unambiguous language in the statute. Based on the proposed rule, CMS is going well beyond the clear, unambiguous language and adopting an interpretation that is not supported by any legislative history.

However, should CMS continue to believe that it has the statutory authority to limit excepted PBDs "as they existed at the time of enactment" based on clinical families, we urge CMS to exclude the imaging clinical families from this provision. Excepted off-campus PBDs should be allowed to expand their suite of services to include imaging clinical families without having to bill for these imaging services on a separate payment schedule.

As mentioned above, the economic viability of imaging on the PFS is waning due to repeated cuts to imaging reimbursement since 2004. Recent cuts to the imaging payments, such as the cut to non-XR-29 compliant CT scans, and the 20 percent reduction for film X-rays, only exacerbate

this issue. If the PFS is the only payment schedule available for new or expanding PBDs offering imaging services, access to these vital diagnostic services will be reduced.

If this proposed rule is adopted as published, CMS will be unnecessarily creating new operational problems for the Medicare claims processing system. We note that even in those situations where an off-campus OPD is willing to expand to offer services in a new clinical family, they will have to wait until 2018 because there is no mechanism at this time to allow for off-campus PBDs to directly bill for these non-excepted services. As a work-around, CMS suggests that the physicians or other practitioners working in off-campus OPDs bill for the non-excepted services on the PFS and through a separate "business arrangement" share the payment with the facility.

Such arrangements are going to be administratively complex and fraught with fraud and abuse potential.

The statute is quite clear that the provision "shall not include a department of a provider (as so defined) that was billing under this subsection with respect to covered OPD services furnished prior to the date of the enactment of this paragraph." Again, nowhere did Congress stipulate that the exception was limited to the services being provided by the department at the time the exception was created.

It is also quite clear that the statutory exception is not contingent on the PBD remaining in the same location or providing similar services as they were before the date of enactment. Prohibiting OPDs that were billing CMS at the time of enactment of PL 114-74 from either moving or expanding services goes well beyond what Congress intended.

Recommendation

It is our recommendation that CMS rescind the language prohibiting an off-campus OPD that was billing Medicare at the time of enactment of PL 114-74 from either moving or expanding into new "clinical family" of services. As outlined above, we believe that there will be a significant number of adverse, unintended consequences if CMS moves forward with this rule as proposed. Instead, CMS could consider simply doing what the statute says by limiting the PFS billing requirement to new off-campus PBDs and remain silent with respect to those PBDs excepted by Congress Section 603. However, if CMS does move forward with the rules on excepted PBDs expanding into new clinical families, CMS should provide an exception to allow PBDs to expand into the imaging clinical families and bill for these services through the OPPS.

3-Proposed OPPS Imaging APC Categories

The AHRA is concerned about the unintended effects of reducing the number of Ambulatory Payment Classifications (APCs) for medical imaging procedures from 17 to 8. While some services will be paid at a higher rate under the new APC categories, many others will be paid at a rate below the cost of furnishing the service.

We are particularly concerned about severe cuts to certain MRI and Ultrasound HCPCS codes. Imaging departments that perform these particular services often, will be hurt considerably by this proposed APC consolidation.

Imaging departments need payment stability in order to properly plan for the future. Considering imaging APCs were restructured less than a year ago, CMS should not restructure the APCs again for CY 2017. Furthermore, because APCs were restructured just nine months ago, there is no data or analysis to support another restructuring of imaging APCs. We find it curious that the only rationale given was that CMS agrees with stakeholder recommendations that further APC consolidation can result in "further improvements."

What exactly has been improved by APC consolidation?

We would also point out that the proposed APC categories contain HCPCS groupings that are not at all clinically homogenous. Rather, it appears that CMS is inappropriately grouping imaging HCPCS based on cost only.

The original legislative mandate states:

> "…the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are **comparable clinically** and with respect to the use of resources and so that an implantable item is classified within the group that includes the service to which the item relates…"

It is apparent that the intent of the language was to preserve clinical similarity. In reviewing the new APC categories, it is clear that CMS ignored clinical context, and thus is not following the intent of Congress. Furthermore, CMS provides no explanation for why certain HCPCS codes are grouped the way they are.

The proposed APC categories will result in steep cuts to certain services that have continuously been reduced by Congress and CMS since 2006. The AHRA cannot support such steep cuts to the MRI and Ultrasound based on a faulty interpretation of the statutory language. Below, we identify some examples of HCPCS codes that we believe are inappropriately grouped in the proposed 2017 APC criteria.

72147 – MRI chest spine w/contrast – 39% cut
70551 – MRI brain stem w/o contrast – 20% cut
70544 – MRI angiography head w/o contrast – 20% cut
71275 – CT abd & pelv w/ contrast – 20% cut
76642 – Ultrasound breast limited – 31% cut
76641 – Ultrasound breast complete – 31% cut
76705 – Echo exam of abdomen – 24% cut
76770 – US exam abdo back wall comp – 24% cut

These services are frequently billed and these cuts will be detrimental to the ability of imaging facilities to offer ultrasound and MRI services.

Should CMS go forward with this APC restructuring, we would ask that the above HCPCS codes be grouped in a more appropriate APC category.

The AHRA agrees with the ACR that radiology, cardiology and all other specialty codes should continue to map to their own clinical families until such time that CMS can articulate a clear concept and criteria for an alternative approach to clinical similarity consistent with the intent of the statute.

CMS should not implement this latest proposal until such time as it has been completely and clearly explained, so that commenters can provide meaningful feedback and so that imaging departments and facilities can have time to understand and prepare for the wide spread impacts association with the proposed re-structuring.

Conclusion

Your consideration of these comments/questions is appreciated. Should you have any questions or need any additional information, please do not hesitate to contact: Sheila M. Sferrella, CRA, FAHRA, ssferrella@regentshealth.com Chair, AHRA Regulatory Affairs Committee.

Sincerely,

Edward J. Cronin, Jr., CAE
Chief Executive Officer