ahra
the association for medical imaging management

September 6, 2016

The Honorable Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–1654–P
P.O. Box 8013
Baltimore, MD 21244–8013

Dear Administrator Slavitt:

On behalf of AHRA: The Association for Medical Imaging Management, we are pleased to submit the following comments on the 2017 Medicare Physician Fee Schedule proposed rule (CMS-1654-P). AHRA 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 the following issues:

1-Transition to Digital X-Ray Imaging – XX Modifier
2-Approprite Use Criteria Implementation

1-Transition to Digital X-Ray Imaging – XX Modifier

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, the rule establishes a new modifier "XX" to be used on any claim for film X-rays. **Are the letters XX placeholders for the actual modifier to be established later? Or is the modifier required for these claims actually going to be XX?**

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 XX 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.

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2- Appropriate Use Criteria Implementation

The AHRA remains supportive of the Appropriate Use Criteria initiative, and we support the ultimate goal of the program. Image ordering decisions by physicians or other clinicians should be based on the diagnostic needs of the ordering health professional. Image payment decisions by Health Plans (including Medicare) should be based on clinical appropriateness, not the financial interests of the Health Plan.

If properly implemented, the AUC initiative represents an opportunity to both improve quality of care for beneficiaries and lower Medicare costs by ensuring that payment determinations are based on clinical criteria developed by Provider-led Entities and not by businesses whose motivation is suspect.

However, we have strong reservations about the currently proposed timeline for AUC implementation. CMS needs to recognize the considerable operational challenges regarding AUC adoption that make a Jan. 1, 2018 implementation date unreasonable. AHRA strongly believes that the AUC consultation requirement should be at least 18 months after the qualified clinical decision support mechanisms (CDSMs) are finalized. If CMS does not finalize the list of CDSMs until July 1, 2017 as proposed, then ordering professionals should not be required to consult AUC until January 1, 2019.

CMS must first finalize the exact mechanisms for appending the AUC consultation information to all types of Medicare claims before any CDSM can be properly developed. If CMS waits until the CY 2018 PFS rulemaking process to establish these mechanisms, the CDSMs will have already been finalized without their most essential function. Put simply, the current proposed timeline puts the cart before the horse.

Consistent with Protecting Access to Medicare Act, the proposed rule requires:

> *that the qualified CDSM must generate and provide to the ordering professional certification or documentation that documents which qualified CDSM was consulted, the name and NPI of the ordering professional that consulted the CDSM and whether the service ordered would adhere to applicable AUC, whether the service ordered would not adhere to such criteria, or whether such criteria was not applicable for the service ordered.*

However, the proposed rule has no guidance on ***HOW*** the CDSMs might be able to communicate these required elements effectively to imaging and billing departments so that they may in turn be able to attach this information to a claim.

How is CMS going to know which CDSM was used, which AUC was consulted, and whether the service adhered to said AUC if each CDSM applicant designs the way they communicate these elements differently? Does CMS envision the creation of some "smart" number by which these elements can be communicated on a UB-04/1450 or 1500 form? If so, how would that work?

These are the questions that need to be answered before the application deadline for CDSMs passes. EHR, RIS, and CDS vendors all need to know how this will work in order to develop the software necessary to support AUC.

The AUC generates three new data elements at the ordering level (CDSM used/AUC used/AUC applicability) that must be communicated from the CDSM, to the RIS, and then to the billing department effectively. Considering that CMS has not even proposed a field on the 1500 or UB-04/1450 in which these elements might be reported, we do not believe that programmers would be able to design a system that effectively passes along the required information until such details are finalized.

Furthermore, because the operational changes to the image ordering and billing process are formidable, they will require significant capital investment to execute. Imaging departments and facilities operate under a budget. Department managers will have difficulty projecting the cost of AUC adoption until after the CDSMs have been announced and mechanisms finalized. Because budgets are typically adopted one fiscal year at a time, imaging departments will not have the time to appropriately budget for and properly execute AUC adoption within just six months.

CMS should understand that imaging departments compete for resources with other institutional departments that may be undergoing similar government mandated changes. Unless we have a time certain/date certain deadline for compliance, it is difficult to argue successfully within an organization for the necessary resources.

The proposed rule solicits feedback on, "whether the information should be collected using HCPCS level II G codes or HCPCS modifiers." AHRA does not see how a HCPCS level II G code or HCPCS modifier would be a flexible enough mechanism to indicate the required AUC data elements to CMS. The best solution would be a standardized smart number that is used by all CDSMs to indicate to CMS the information required. This would be in addition to the unique ID number generated by every single consultation with the CDSM.

CMS notes that "Moving too quickly to satisfy the reporting requirements could inadvertently result in technical and operational problems that could cause delays in payments." It is the AHRA's expert opinion that the current timeline fails on all accounts. It moves too quickly and it would create immense technical and operational problems resulting in long delays in claims submission, processing, and payments.

AHRA suggests CMS adopt the following timeline to avoid these issues:

January 1, 2017 – CMS finalizes mechanisms for reporting the required AUC data elements
March 1, 2017 – Deadline for CDSM applicants
July 1, 2017 – CDSM list finalized
January 1, 2019 – Ordering professionals begin AUC consultation

AHRA also seeks clarification for instances where an image was ordered while a patient was in observation status. Since the ordering professional does not know if the patient will transition to inpatient status, and thus be excepted because the services are paid under Medicare Part A, or be discharged before 23 hours and thus bill under the OPPS, will the AUC consultation requirements apply?

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,

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Chief Executive Officer

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