ahra
the association for medical imaging management

September 10, 2017

The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Attention: CMS–1676–P
P.O. Box 8016
Baltimore, MD 21244–1850

Dear Administrator Verma:

On behalf of AHRA, The Association for Medical Imaging Management, we are pleased to submit the following comments on the 2018 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1676-P). AHRA is the professional organization representing management at all levels of hospital imaging departments, freestanding imaging centers, and group practices. Founded in 1973, AHRA's 5000 members reach across the country and around the world.

Our comments are focused on:

1-Appropriate Use Criteria for Advanced Diagnostic Imaging Services
2-Proposed Payment Rates for Nonexcepted Services

1-Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Timeline for Implementation

First and foremost, AHRA would like to express our thanks to JoAnna Baldwin, Sarah Fulton, Katherine Szarama, Joseph Hutter and the entire Appropriate Use Criteria (AUC) team at CMS for listening to stakeholder concerns regarding implementation timeline.

AHRA strongly supports CMS's proposal to delay the AUC implementation until January 1, 2019. This should give ordering professionals, imaging centers, billing departments, and all other relevant parties the time needed to better implement AUC. We are glad that CMS is giving consideration to the operational and technical challenges AUC poses and allowing the industry time to work through these issues.

After listing the considerable challenges and considerations of AUC implementation, CMS writes:

> For these reasons an educational and operations testing period is needed. During this period, ordering professionals would consult AUC and furnishing professionals would report AUC consultation information on the claim, but we would continue to pay claims whether or not they correctly include such information.

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AHRA supports this "educational and operations testing period" proposal. We agree with CMS that such a period will help ordering and furnishing professionals make the necessary adjustments before payment and access to imaging services is disrupted. However, we would ask CMS to clarify exactly what they expect during this educational and testing period:

> During the educational and testing period, does CMS expect *some* AUC consultation information on all applicable Medicare claims? In other words, during the educational and testing period, if there is no AUC consultation information whatsoever on the claim, would that claim still be paid?

Clarify that Ordering Professionals Must Consult the AUC <u>Personally</u>

AHRA believes that, consistent with the intent of the AUC program, CMS should clarify that ordering professionals must consult AUC personally. There are some that believe that AUC consultation through a qualified Clinical Decision Support Mechanism (CDSM) is something that the ordering professional can contract out to some other entity.

We disagree with this belief based on the language released by CMS thus far. However, we ask that CMS clarify that such an arrangement is not permissible because if such arrangements are allowed, it defeats the main goal of the program: to educate ordering professionals on the medical appropriateness of their imaging orders.

<u>CMS should be unequivocal in the final rule that ordering professionals are required to use CDSM to consult AUC personally.</u>

Concerns Regarding Reporting AUC Information on Claims

AHRA has concerns about the proposed methodology for attaching AUC information to claims. Primarily, we believe that the "G-codes with modifier" approach will require a human or manual edit for each and every claim. As you might imagine, the cost and potential for error of this approach is considerable.

While there is significant variance amongst imaging and billing software and processes, AHRA believes that CMS could develop a better methodology that avoids these manual steps. AHRA recommends that CMS collect AUC information via a CDSM-generated "smart number" that would be appended to the authorization fields (Field 63 on the UB-04, Field 23 on the CMS-1500).

The primary advantage to the "smart number" approach is that it mirrors the workflow that imaging centers use to indicate pre-authorization codes to commercial insurance payers. As such, it would allow providers to implement the AUC program in the least disruptive and most effective manner. We understand that there are limitations to using the authorization fields. However, it is imperative that CMS dedicate the resources to overcoming those limitations given the significant volume of claims that will require AUC information.

We note that currently, qCDSMs are required to generate a "unique consultation identifier" and that this identifier must be on the certification or documentation produced at the time of the order. We believe that CMS should utilize this unique consultation identifier as a "smart number" for AUC information reporting purposes.

Regardless of the final AUC reporting method CMS adopts, we believe that CMS should require qCDSMs to generate the information needed for AUC reporting every time the qCDSM is used. For instance, if CMS finalizes the G-codes with modifiers approach as proposed, the qCDSMs, should automatically generate the G-code and modifier for every single consultation. This simple step would save time and resources for all involved in the AUC process.

Again, we recognize that there are CMS system limitations to our smart number approach. However, we believe that these can be overcome. AHRA would point to the approach that commercial payers use for pre-authorization as proof that several smart numbers can be appended to a claim and processed accordingly. Additionally, because commercial payers already collect and review the data in the authorization fields prior to paying the claim, there should be existing claims processing solutions available to CMS.

Our goal is to move the required data elements from the CDSM all the way through to the claim as seamlessly as possible. We believe that the "G-code with modifier" methodology will create administrative burdens and costs that could be avoided with a better approach. Our suggested alternative is similar to existing and functioning workflows and therefore we feel that it is a better way to implement the AUC program.

We have attached several workflows covering three different scenarios for CMS to review. These workflows were created to show how we would prefer the workflow to go, not how we would implement the rule as currently proposed.

We are happy to work with CMS staff to come up with a solution that works for both CMS's claims processing system and the imaging community. To this end, we suggest that CMS create a working group with AUC stakeholders.

AHRA notes that a comparable working group was created to address Medicare provider enrollment reforms. The "PECOS Power User Group" had success bringing stakeholders and CMS together to work through complex system changes and we feel that a similar model could work well for AUC/CDSM. Working together to stand up a new requirement that works for CMS and the industry will give us the best chance at finding the right approach. Given the significant volume of claims affected, we urge CMS to invest the operational resources needed to make the AUC program work for both providers, CMS and Medicare beneficiaries.

Questions Regarding Emergency Exemption

AHRA understands that there are emergency exceptions to the AUC program based on the "emergency medical condition" definition found in section 1861(e)(1) of the Social Security Act (SSA). However, it is unclear to us if this definition is comprehensive enough to work for the purposes of AUC.

The definition found at 1861(e)(1) is primarily used today to determine if an emergency department turned away a patient who was in need of emergency medical care. It is not typically used to evaluate the patients that an emergency department (ED) does choose to see. Almost by default, any patient that presented at an ED could be rationalized as in "emergency medical condition." Therefore, it seems as if all ED patients that are not triaged to outpatient providers would qualify for an emergency exception.

AHRA believes that all imaging claims for ED patients should be exempt from AUC. As such, we ask CMS to clearly state that all ED Medicare patients are exempt from AUC.

However, if this is not CMS's interpretation, additional definitions would be needed to clarify when the emergency exception applies, and when it does not. In general, we want to avoid any AUC process resembling the medical necessity process we have today. Our primary concern is that an image would be performed and billed under the presumed AUC exception, but then denied by Medicare after the fact for a lack of AUC consultation.

National Coverage Decisions and Local Coverage Decisions for Imaging Orders that Adhere to AUC

AHRA believes that if an imaging order adheres to any AUC, then that imaging order should be covered by Medicare. We believe there may be instances whereby the imaging order adheres to the AUC but the LCD or NCD will not pay for that service. This is a scenario that is confusing for providers and should be avoided. CMS should ensure that any NCD or LCD does not overrule clinically-based criteria.

Estimate of Cost of AUC Implementation

AHRA is concerned that the OMB only considered ordering professional costs when estimating the overall burden of AUC implementation. We strongly disagree that the changes imaging centers will have to make to their IT systems are "usual and customary" business costs and thus exempt from review under the Paperwork Reduction Act.

The OMB notes that "99 percent of all Medicare claims are submitted electronically" but does not take into consideration that a significant portion imaging orders are actually still made via paper/fax.

The furnishing provider's scheduler will typically have to gather the AUC information from the patient or the referring provider's office before scheduling the appointment. Considering that this information is currently not proposed to be similar to any other pre-authorization process, this will add a significant amount of administrative time to the scheduling process.

Furthermore, we disagree with the OMB statement that the "proposed reporting requirement would not have any impact on any Medicare claim forms because the forms' currently approved data fields, instructions, and burden are not expected to change." The current CMS proposal certainly adds additional instructions for filing Medicare claims, and uses data fields in new

ways that make it difficult to automate. Therefore, we respectfully reject the notion that implementing the AUC requirements as proposed by CMS results in only usual and customary compliance cost.

AHRA requests that the OMB reconsider their determination that the AUC reporting requirements do not qualify for review under the Paperwork Reduction Act.

2-Proposed Payment Rates for Non-excepted Services

AHRA strongly disagrees with the proposal to pay for non-excepted services at 25% of their OPPS rates. This does not lead to "site neutral" payment policy. Instead, this incentivizes non-excepted HOPDs to convert to freestanding facilities, especially those that furnish a heavy volume of imaging services. This was never the intent of Congress and CMS should revert back to the 50% relativity adjuster until such time that they can develop a more nuanced payment system for non-excepted services.

Furthermore, non-excepted HOPDs had no reason to believe an additional halving of their payment rate was forthcoming from CMS. This sudden and severe payment cut will make it difficult for the non-excepted HOPD model to survive.

The 25% PFS Relativity Adjuster proposed by CMS ignores the realities of outpatient care and results in unsustainably low reimbursement. Additionally, the reasoning offered by CMS in the proposed rule is not apparent. AHRA understands that the 25% PFS Relativity Adjuster is based on the relative payments for the Evaluation and Management codes (99201-99205 and 99211-99215). However, no rationale as to why this approach was better than the previous approach is offered.

CMS writes in the proposed rule: "we believe that the comparison between PFS and OPPS payment for the most common services furnished…is a better proxy than our previous approach." AHRA does not understand why it is better to base the relativity adjuster between two payment systems that encompass the entire array of medical services furnished in outpatient settings on just one aspect of outpatient care. While Evaluation and Management visits are certainly the most common services, outpatient facilities perform significant volumes of other services, such as imaging, that deserve consideration when determining the relative adjustment.

CMS's own analysis in Table 9 which compares the OPPS and PFS payments of 22 of the most commonly billed codes (besides the E/M codes) shows that the weighted average of PFS payment is 45% of the OPPS payment. AHRA notes that the 45% figure is only based on 22 codes, and therefore still an inaccurate analysis of the differential payment systems, at least it approximates the relative payments across different types of services.

In many cases, use of the 25% PFS relativity adjuster will drop the reimbursement for imaging services below the costs of furnishing that service. This will cause non-excepted HOPDs to either no longer offer this service to Medicare patients or convert to freestanding centers that can bill the PFS.

Finally, AHRA wishes to reiterate that the numerous cuts to the TC of the MPFS since 2006 have tremendously hurt the revenue of the freestanding imaging center model. The Medicare payment systems available to new imaging centers are prohibitive from a business standpoint. Both freestanding and hospital-owned off-campus imaging centers have increasingly infeasible payment options, As a result, we are concerned that availability of services may not meet patient demand.

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