Medicare Red Tape Relief Project
Submissions accepted by the Committee on Ways and Means, Subcommittee on Health

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Name of Submitting Organization: The Provider Roundtable (PRT)

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Please describe the submitting organization's interaction with the Medicare program:

The Provider Roundtable (PRT), is a group of providers who generate substantive comments with an operational focus on a variety of CMS programs, including Medicare. The PRT has representatives from 10 health systems, serving patients in 28 states. As hospital employees, PRT members have a financial interest in fair and proper payment for hospital services under Medicare. The members appreciate the opportunity to provide our comments to the Committee.

In the case of listed Appendices, please attach as PDF files at the end of the submission, clearly marked as "Appendix [insert label]"

The Provider Roundtable membership list is included as an attachment

Submissions on:

1. Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging.
2. 2nd Important Message from Medicare requirement.
3. Observation carve-out for hours that include "active monitoring."
4. Medically Unlikely Edits (MUEs) for Outpatient claims for packaged services.
5. "Three Consecutive Day Inpatient Hospital Stay" requirement.
6. Coverage policies for lab services (i.e., Local Coverage Determinations and National Coverage Determinations.
7. Inpatient-Only list.

1. Short Description: The proposed Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging should either be eliminated or CMS' implementation plans should be significantly modified in order to reduce provider burden.

Statutory ☑ **Regulatory** ☐

Summary: In order to implement Section 218(b) of the Protecting Access to Medicare Act (PAMA), CMS proposes regulations that would require furnishing providers to report Appropriate Use Criteria (AUC) for advanced diagnostic imaging. The proposed regulations require furnishing providers to enter HCPCS codes and modifiers on advanced diagnostic imaging service claims in order to receive payment. These HCPCS codes and modifiers would report what AUC were accessed, through which Clinical Decision Support Mechanism (CDSM), and whether the diagnostic test adhered to those criteria. This proposal presents myriad administrative burdens for furnishing providers (both physicians and hospitals), given that these facilities are not necessarily the ordering providers. Burdens are created by the need to obtain the required information from the ordering provider, translate the information into the appropriate codes, and develop a process for entering information onto the claims. The proposed process also increases the risk of delaying patient care while the required information is being obtained from the ordering provider, and of hospitals billing for services that do not meet AUC. In the 2018 Medicare Physician Fee Schedule (MPFS) Proposed rule, CMS estimates ordering providers' annual cost for this program to be $275,139,000 ($275 million). This figure does not even take into account the costs to the furnishing providers (i.e. hospitals and/or interpreting physicians). CMS also states that the Congressional Budget Office estimates that PAMA will save $200 million over 10 years. The cost of the program far outweighs its potential benefits. The PRT believes that the resources required to implement the AUC program would be better applied toward promoting Value-Based Purchasing and improving beneficiary care.

Statute/Regulation: Section 218(b) of the Protecting Access to Medicare Act of 2014 amended Title XVIII of the Social Security Act to add section 1834(q), which directed CMS to establish a program to promote AUC for advanced diagnostic imaging services.

Proposed Solution: The PRT proposes that this program be eliminated in its entirety. If this is not possible, the PRT recommends that CMS be instructed to apply the AUC requirements to ordering physicians and practitioners rather than to furnishing hospitals and other suppliers. We additionally request that CMS be instructed to require that the approved CDSM provide information directly to CMS. This is preferable than the burdensome proposal that providers and physicians develop a costly claim reporting process. We also note that the latter approach has a large risk of reporting errors, service delays, and unnecessary claims denials.

2. Short Description: The requirement to provide beneficiaries with a 2nd Important Message from Medicare should be eliminated.

Statutory ☐ Regulatory ☑ Specifically, SUB-REGULATORY

Summary: Currently, based on subregulatory requirements, hospitals are required to provide beneficiaries with a written explanation of their appeal rights, and to obtain the beneficiary's signature attesting to having received this explanation, at the time of his or her admission to the hospital. This process is called "Important Message notification." If this Important Message notification was provided more than two days before the patient's discharge from the hospital, CMS requires the facility to provide the beneficiary with a second Important Message notification (i.e., a follow-up notification). This second notification provides information identical to that contained in the initial notice. Presenting a beneficiary with the exact same information twice during one hospital stay often results in patients feeling both confused and overwhelmed by paperwork. This requirement also causes waste and redundancy for the hospital and staff, by consuming time and resources required to produce the duplicative paperwork.

Related Statute/Regulation: Subregulatory requirements (see above)

Proposed Solution: The PRT recommends the elimination of the requirement to provide beneficiaries with the second Important Message notification. We believe that any benefits gained by presenting the second (duplicative) message are outweighed by the increased likelihood of confusion and frustration on the part of the patient, and the waste incurred on the part of the facility.

3. Short Description: When counting and billing observation hours, CMS requires hospital facilities to remove any observation hours that include "active monitoring."

Statutory ☐ **Regulatory** ☑ **Specifically SUB-REGULATORY**

Summary: When counting and billing observation hours, CMS requires hospitals to remove (i.e., "carve out") any observation hours during which diagnostic or therapeutic services that require "active monitoring" are provided. Complying with this requirement creates operational and administrative burdens for providers, in two ways. First, the definition of "active monitoring" is left up to individual hospitals to determine and the definition of "active monitoring" is difficult to interpret. In fact, the active monitoring that may be included in the charge for the service would not include the additional monitoring that would be required for an observation patient – a patient whose condition is such that they need to remain in the hospital, as opposed to an ambulatory outpatient. Second, in order to comply with the regulations, facilities frequently use a manual process to remove observation hours that include active monitoring. Because most observation care is packaged, hospitals conduct this work despite the fact that it does not impact their payment. Further, the requirement was created in order to prevent "double payment" of services when the Composite Extended Assessment and Management (EAM) APCs were in use. CMS eliminated the Composite EAM for CY2016, and now uses Comprehensive APCs (C-APC) for Observation Services. Hence, the manual provision and billing requirement that once applied to Composite EAMs has no further application or utility.

Related Statute/Regulation: Subregulatory - *Claims Processing Manual*, Chapter 4 Section 290.2.2

Proposed Solution: The PRT recommends the elimination of the requirement that hospitals "carve out" hours during observation that include active monitoring. Our proposed solution is to strike the following paragraph from Internet Only Manual (IOM) Publication 100-04, Chap 4, Sec 290.2.2:

> Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

4. Short Description: Medically Unlikely Edits (MUEs) for Outpatient claims for packaged services should be eliminated.

Statutory ☐ **Regulatory** ☑ **SPECIFICALLY SUB-REGULATORY**

Summary: A Medically Unlikely Edit (MUE) is a unit of service (UOS) edit; it is used for services that are rendered by a single provider to a specific beneficiary on the same date of service. MUEs are intended to report medically reasonable and necessary UOS in excess of an MUE value. If an MUE is adjudicated as a claim line edit or a date of service edit, UOS that exceed the MUE value may be appealed. While it is not typical for MUE edits for UOS per patient per provider to be exceeded, it does happen occasionally. (It occurs, for example, with drugs, because CMS caps allowable dose units at a patient weight of 110 kg, and many of today's beneficiaries are overweight or obese and exceed this cap.) When this situation occurs, hospital billing departments are forced spend significant amounts of time checking back with clinical departments about the issue. The clinical departments, likewise, must spend time checking medical records to verify the MUE's validity. Across hospitals, this time adds up and creates a significant administrative burden and waste of resources. Furthermore, the edits result in denial of the entire line item (including services that are under the limits being denied). CMS does not make any additional payments for packaged services under OPPS; for this reason, there is no practical reason that hospitals should appeal the denial, since the appeal will not result in additional payment. As a result of these edits, providers are administratively barred from submitting medically-necessary costs to CMS.

Related Statute/Regulation: This is a sub-regulatory issue; specifically, it stems from CMS' *National Correct Coding Initiative,* which is described on the agency website at https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Proposed Solution: The PRT recommends that MUEs be disabled for outpatient hospital claims for packaged services.

5. Short Description: The "Three Consecutive Day Inpatient Hospital Stay" requirement for post-hospital extended stay services should be eliminated.

Statutory ☑ **Regulatory** ☐

Summary: Currently, a patient must spend three days (i.e., 72 hours) as an inpatient in an acute care hospital before Medicare will pay for post-hospital extended care services. These post-hospital extended care services include those provided by a skilled nursing facility (SNF). Part B outpatient hospital services — such as observation hours and time in the Emergency Department — do not count towards this three-day requirement. When a patient no longer needs acute care services and a SNF bed is available, the PRT believes that the patient should be transferred to the lowest level of care that continues to meet the patient's needs. And, we believe that Medicare should cover the cost of this stay.

Related Statute/Regulation: Section 1861(i) of the Social Security Act

Proposed Solution: The PRT recommends the elimination of the 3-day inpatient hospital stay requirement. The proposed solution is to amend the statute and delete the words "for not less than 3 consecutive days." The updated statue would read: "(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient or outpatient ~~for not less than 3 consecutive days~~ before his discharge from the hospital in connection with such transfer…"

6. Short Description: Coverage policies for lab services (i.e., Local Coverage Determinations and National Coverage Determinations) should be eliminated.

Statutory ☑ **Regulatory** ☐

Summary: As a result of the 1997 Balanced Budget Act, CMS entered into negotiated rulemaking proceedings to develop National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs) for clinical diagnostic laboratory services. NCDs and LCDs determine whether Medicare deems a test to be medically necessary and the agency only pay for the ones that are medically necessary. For hospital outpatient departments at the present time, however, most clinical laboratory services are packaged. For this reason, the continued use of NCDs and LCDs for lab services creates administrative burden for facilities. The burden stems from the need for facilities to determine medical necessity when the patient presents, issue an Advanced Beneficiary Notice (ABN) about lab services potentially not being covered, adjust claims to lab services, and appeal claims that are denied. Further, this extra effort does not create benefits for the provider or cost savings for CMS. In addition, the ABN creates confusion and anxiety on the part of beneficiaries, and discourages them from seeking care.

Related Statute/Regulation: Section 4554 of the Balanced Budget Act of 1997.

Proposed Solution: The PRT recommends that outpatient hospital services be excluded from outpatient NCDs and LCDs related to clinical diagnostic laboratory services. We believe that CMS should eliminate coverage policies for any service that does not generate separate payment under OPPS (i.e., any "packaged service").

7. Short Description: The Inpatient-Only list, which specifies procedures that may only be performed in the inpatient setting, should be eliminated.

Statutory ☐ **Regulatory** ☑

Summary: The Inpatient-Only List, which specifies surgical procedures that are required to be performed on an inpatient basis, is burdensome to both physicians and hospitals. It creates confusion for physicians, who have been extensively trained to select the most appropriate level of care for patients based on that individual's medical condition and expectation of 2-midnights of hospital care, rather than the type of procedure being performed (i.e., inpatient vs. outpatient). It is burdensome to hospitals because, in order to comply with the Inpatient-Only List, hospitals must use resources to monitor coding not only of scheduled surgical procedures but also of the numerous additional procedures that may occur on an unplanned basis during a scheduled procedure. When the latter event occurs, and a procedure that appears on the Inpatient-Only List is performed during outpatient procedures, the patient must be admitted as an inpatient so the hospital can receive payment for the care provided. This inpatient admission must occur whether or not the inpatient level of care is medically necessary for that patient. Furthermore, the list of inpatient procedures uses CPT codes, while hospitals bill inpatient procedures using ICD-10PCS codes. CMS does not publish a crosswalk between the two, which complicates facilities' ability to map from one to the other. Hospitals face additional burdens stemming from CMS contractor audits of one-day inpatient accounts when the account is correct under the current Inpatient-Only policy. Finally, the Inpatient-Only List unnecessarily increases Medicare expenses by forcing procedures to be conducted in the inpatient setting (which has higher payment rates than the outpatient setting) long after technology and medical advances have made them safe for the outpatient setting.

Related Statute/Regulation: 42 CFR 419.22(n)

Proposed Solution: The PRT has repeatedly urged CMS to eliminate the Inpatient Only List. The decision on the type of care needed should rest with the physician/practitioner based on his or her personal knowledge of the specific patient and the care needed. Eliminating the Inpatient-Only List will reduce CMS' costs for both payments and audits. It will also reduce hospitals' administrative burden need to comply with the regulation by monitoring extensive coding activities and enforcing the requirements.