Avera Health
(IA, MN, NE, ND, SD)

Ascension Health
(AL, AZ, AR, CT, DC, FL, GA, ID, IL, IN, KS, KY, LA, MD, MI, MO, MN, MS, NY, OK, PA, TN, TX, WA, WI)

Baptist Health South Florida
(FL)

Carolinas HealthCare System
(NC, SC)

Community Hospital Anderson (IN)

Erlanger Medical Center
(TN)

Franciscan Missionaries of Our Lady Health System
(LA)

Hartford Hospital
(CT)

Kaiser Permanente, Southern California Permanente Medical Group
(CA)

University of Pittsburgh Medical Center
(PA)

August 17, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Re: CMS-1676-P

Dear Administrator Verma:
The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers who gathered to generate comments on the 2018 *Medicare Physician Fee Schedule* (*MPFS*) Proposed Rule, as published in the *Federal Register*.

The Provider Roundtable (PRT) includes representatives from 10 different health systems, serving patients in 28 states. PRT members are employees of hospitals. As such, we have financial interest in fair and proper payment for hospital services under the MPFS, but do not have any specific financial relationship with vendors.

The members collaborated to provide substantive comments with an operational focus that we hope CMS staff will consider during the annual MPFS policymaking process. We appreciate the opportunity to provide our comments to CMS. A full list of the current PRT members is provided in **Attachment A.**

Please feel free to contact me at 765-298-2110 or via email at: *trinker@ecommunity.com*.

Sincerely,

Terri Rinker, MT (ASCP), MHA (Chair)
PRT Chair and
Revenue Cycle Director
Community Hospital Anderson
Anderson, IN

Summary of Recommendations

In the comment letter that follows, the PRT makes the following recommendations, summarized here and described in more detail below:

Medicare Telehealth Services

- The PRT recommends that CMS eliminate the requirement to report modifiers -GT and –GQ.
- The PRT encourages CMS to work with all appropriate Federal agencies to enhance veterans' access to care.
- The PRT recommends that CMS revisit Telehealth regulations and relax the boundaries demarcating where an originating site must be located for the Medicare population, in order to foster better access to needed care.

Proposed Payment Rates Under the Medicare PFS for Non-excepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital

- The PRT strongly urges CMS not to implement any rate adjustments for at least two years after implementation of the -PN modifier.
- The PRT urges CMS to base its future analysis on the top 25 reported codes, including *procedures* performed, given the data above and CMS' own methodology used for CY 2017.
- The PRT recommends that CMS compare procedures performed in POS 19 to those performed in POS 11 and use claims analysis to assess the need for an adjuster for procedures that are always performed in a physician's office.
- The PRT encourages CMS to exempt from payment reduction all CPT-coded procedures that *never* occur in POS 11, since these procedures have no payment differential with the physician office.
- The PRT urges CMS to conduct further data analysis on the proposal's procedural aspects.
- The PRT requests that CMS provide a technical clarification regarding the National Uniform Billing Committee (NUBC) requirement to report the locations address in form locator 1 of the UB-04 when a patient is seen/treated in multiple locations on the same date of service.

Evaluation & Management (E/M) Guidelines and Care Management Services

- The PRT supports CMS's proposal to restructure the E/M requirements for HPI and Physical Exam, and recommends that the agency eliminate the required use.
- The PRT recommends that CPT code guidelines be used to document the patient's history, physical examination, clinical picture, and general consistency with medical decision-making.
- The PRT requests that CMS immediately suspend and end any E/M audits in which its contractors are engaged.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

- The PRT strongly recommends that the mandatory use/implementation of AUC for advanced diagnostic imaging services be delayed to at least CY 2020, and that there be no payment impact to providers before CY 2020.
- The PRT encourages CMS to expand the voluntary reporting period through the end of CY 2019, begin its educational and operational testing period in CY 2019, and continue this period through CY 2020.

- The PRT recommends that the educational and operations testing period should last through CY 2020.
- The PRT urges CMS to conduct listening sessions with providers during the initial implementation requirement, to understand the challenges providers are encountering.
- The PRT recommends that CMS provide instructions related to orders written prior to the effective dates (i.e., reporting and denial) of the requirement, when the service is provided after the implementation of the AUC reporting requirement's two phases.
- The PRT suggests that CMS define the required information an ordering professional must include related to the AUC consultation on *every* referral to a furnishing provider for the applicable imaging services. The required information must include the HCPCS code for the CDSM and the applicable modifier for the consultation related to the ordered test. This will facilitate entry of the information and assign responsibility for accurate determination of the HCPCS and modifier to the ordering provider. This will also insure the integrity of the data that CMS will receive since the ordering provider has the responsibility of consulting the appropriate AUC.
- CMS should define what it views as reasonable efforts made by the furnishing provider to obtain AUC consultation information from the ordering provider. CMS should also specify steps that can be taken with respect to rendering the service after those reasonable efforts have been made. (For example, may the furnishing or interpreting provider obtain the AUC consultation on behalf of the ordering provider, using information contained on the order? How should beneficiary complaints regarding delay of service be handled?)
- CMS should clarify how, on claims with multiple lines of applicable services, the AUC consultation will be linked to each individual service.
- The PRT believes that CMS should use the education and operations testing period to identify ordering providers who may not be adhering to the AUC consultation requirement, and then provide focused outreach and education activities to these providers.
- The PRT encourages both CMS and its contractors to provide direct communication encouraging ordering physicians to comply with the program.
- The PRT recommends that CMS use a G-code to identify circumstances where no AUC consultation could be reported, and establish a modifier to indicates the ordering provider did not report an AUC consultation to the furnishing provider.
- The PRT suggests that CMS (or its contractors) track and trend the use of the code and modifier combination to identify ordering providers who need focused education about this requirement.
- The PRT recommends that CMS define the proposed modifier to be used when an AUC consultation is not made due to the presence of an EMC condition such that it includes a suspected EMC as well.
- The PRT suggests that ordering providers that have been granted significant hardship exceptions be required to include the appropriate G-code and modifier on orders for advanced imaging services.
- The PRT encourages CMS to create some type of identifier for providers that have obtained a hardship exception and make public information about these providers, and their initiation and discontinuation dates for the exception.
- The PRT requests CMS to provide guidance about situations when the interpreting physician performs different or additional tests than those ordered, in accordance with the guidance in 100-02, Chapter 15, Sections 80.6.2 – 80.6.4.
- The PRT recommends that CMS clarify that a CDSM response indicating an ordered

imaging service does not adhere to AUC criteria does not necessarily imply that the services were not medically necessary and reasonable.

- The PRT urges CMS to prohibit post-payment reviews based upon AUC criteria not being met for a specific imaging service.
- The PRT recommends that CMS exempt, from the AUC consultation requirement, claims for services that are determined, after an AUC-related service has been provided, to be ineligible for inpatient Part A coverage. This would include claims billed as inpatient Part B and claims that were improperly assigned inpatient status and later billed as outpatient, when an appropriate order is present.

MACRA Patient Relationship Categories and Codes

- The PRT recommends that CMS clarify the timeframes during which the proposed modifier use will be voluntary vs. mandatory.
- The PRT urges CMS to create mechanisms by which the agency can receive adequate data to set payment rates, without endangering reimbursement. A one-year window for mandatory data provision without payment impact would provide sufficient time for data collection and analysis, education, implementation, and operationalization.

ICRs Regarding Appropriate Use Criteria for Advanced Diagnostic Imaging Services

- The PRT recommends that CMS re-visit its estimate of the impact to include the regulatory burden to rendering/interpreting providers, and publicize the resulting estimate to the provider community.
- The PRT encourages CMS to require CDSMs to interact with EHRs in order to report the information needed regarding the CDSM consultation.
- The PRT urges CMS to find another method for capturing this information rather than putting such an enormous burden on rendering/interpreting providers.

Medicare Telehealth Services

The Provider Roundtable (PRT) commends CMS' efforts with respect to the development and expansion of Telehealth Services for CY 2018. CMS recognizes Telehealth's broad capabilities and the ways in which it has transformed the health care industry. Digital health experts predict that technology will change how patients receive services by shifting a larger amount of care to both telemedicine and mobile apps. Telehealth will continue to grow exponentially as people increasingly live in a technologically-immersed world, enabling patients to have expanded choices in how they access physicians and/or specialist services.

New Codes

The PRT appreciates CMS for adding two new HCPCs codes and five new CPT codes in the development efforts of the list of approved Telehealth services:

- HCPCS code G0296: Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision-making)
- HCPCS code G0506: Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
- CPT code 90785: Interactive complexity (list separately in addition to the code for primary procedure)
- CPT code 90839: Psychotherapy for crisis; first 60 minutes
- CPT code 90840: Psychotherapy for crisis; each additional 30 minutes (list separately in addition to code for primary service)
- CPT code 96160: Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument (e.g., depression inventory)
- CPT code 96161: Administration of caregiver-focused health risk-assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

  The PRT supports the addition of these services to the Telehealth list, which will make it administratively easier for practitioners and providers alike to report these services in association with a visit code.

Elimination of Telehealth Modifiers

The PRT appreciates CMS' proposal to eliminate the required use of the Telehealth modifier –GT (via interactive audio and video telecommunications systems) on Professional Claims when reporting Telehealth Services.

Currently, CMS instructs practitioners and providers to submit claims for Telehealth services using the appropriate CPT or HCPCS code for the professional service, along with the –GT modifier. Federal telemedicine demonstration programs in Alaska or Hawaii are instructed to submit claims using the appropriate CPT or HCPCS code and Telehealth modifier –GQ, if Telehealth services are performed "via an asynchronous telecommunications system." In the CY 2017 PFS Final Rule (81 FR 80201), CMS finalized payment policies regarding Medicare's use of a new Place of Service (POS) Code describing services furnished via Telehealth. The new POS code became effective

January 1, 2017.

CMS states that the use of this POS code is redundant with the previous requirements to apply the –GT modifier for Telehealth services. A valid POS code is required on professional claims for all services, and appropriately reporting the Telehealth POS code indicates both the provision of the service via Telehealth, and certifies that the requirements have been met. For this reason, the PRT believes it is unnecessary to also require distant site practitioners to report the –GT modifier on claims. The elimination of the requirement to report -GT or –GQ will also benefit efforts to minimize providers' and practitioners' burden of information collection, as well.

- The PRT recommends that CMS eliminate the requirement to report modifiers -GT and –GQ.

In addition, the PRT notes that the Department of Veterans Affairs (VA) announced a new Telehealth initiative on August 3, 2017, which pairs regulatory changes with a new mobile app to expand veterans' access to needed health care. The new initiative, called "Anywhere to Anywhere VA Health Care," allows VA providers to treat veterans anywhere in the country using Telehealth technology, *regardless of where the provider practices*. Until this initiative, the VA's providers were barred from providing Telehealth services across state lines. The VA is currently working with both the White House's Office of American Innovation and the U.S. Department of Justice on new regulations that will allow providers to practice within the scope of their specialty anywhere in the country.

The PRT supports these efforts and encourages CMS to work in partnership with all appropriate Federal entities to ensure that veterans' access to needed health care is enhanced to the fullest extent possible. In addition, the PRT believes that the agency should review this initiative with respect to the ability to practice "across state lines" via telemedicine for Medicare beneficiaries. This would help to ensure that beneficiaries in areas for which telemedicine is designed have quicker access to this needed discipline.

- The PRT encourages CMS to work with all appropriate Federal agencies to enhance veterans' access to care.
- The PRT recommends that CMS revisit Telehealth regulations and relax the boundaries demarcating where an originating site must be located for the Medicare population, in order to foster better access to needed care.

Proposed Payment Rates Under the Medicare PFS for Non-excepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital

The PRT has fundamental concerns related to the additional payment reduction being proposed for CY 2018. In the last rulemaking cycle, CMS requested comments about the 50 percent reduction, which was an interim payment policy for CY 2017 for non-excepted off campus provider-based departments (PBD). We note that CMS never responded to the comments the agency received on this reduction, nor released any analysis of this issue.

CMS stated in the 2017 OPPS Final Rule:

"Therefore, in that proposed rule, we noted that we intended the payment proposal to be a

temporary 1-year policy, applicable in CY 2017 only, while we continued to explore operational changes that would allow nonexcepted items and services to be billed by the off-campus PBD under the applicable payment system, which, in the majority of cases, would be the MPFS (81 FR 45687 through 45689).”

Two members of the PRT work at facilities that understood the “temporary” 50 percent reduction with further analysis to be complete. As a result, these providers moved forward with plans to open a non-excepted off-campus department. Providers thought, with good reason, that the “temporary reduction” would be in place until CMS evaluated claims data. Providers took CMS’ intentions and statements on good faith, and believed the agency would not only consider the comments it received but also evaluate the applicable claims data before finalizing the reduction.

None of this has occurred, however. (Or, if it has, the results have not been shared with the provider community.) The PRT is extremely concerned that CMS proposes to take the 50 percent reduction (which it deemed an interim step that was open to comment since it was based on data that CMS itself admitted did not provide a “one-to-one correlation”) and add *an additional 25 percent reduction in payment*. We feel this is unconscionable. This proposal does not reflect CMS’ stated intention for the 50 percent reduction to be an interim measure. The agency has not fully responded to the comments it received or evaluated the reduction using two years of claims data. Both activities must be conducted before a further reduction can even be considered by CMS.

We also are stunned that CMS issued this proposal in the same year that the agency is proposing a payment reduction for 340B drugs. If both proposals are finalized, the cumulative impact of these two proposals on hospitals would be devastating. The compounded effort involved in serving beneficiaries and low-income, dual-eligible patients is becoming a huge concern as facilities and physicians attempt to provide accessible and affordable services to beneficiaries and other needy patients in medically underserved areas.

The PRT feels very strongly that it would be egregious for CMS to advance this proposed payment reduction without further analysis and discussion. (We are also presenting our significant concerns in our comments on the OPPS Proposed Rule.)

The PRT strongly urges CMS to pause on *any* rate adjustments for at least two years after implementation of the -PN modifier. The agency currently lacks sufficient data to thoroughly evaluate the rate comparison from hospital off-campus PBD procedures and visits to office-based procedures and visits. Hospitals have not had any cost reduction in the off-campus site location PBD requirements related to the hospital’s cost of operations, but continue to operate based on need and location of beneficiaries.

- The PRT strongly urges CMS not to implement any rate adjustments for at least two years after implementation of the -PN modifier.

CMS requests comments on its methodology for determining future payment rates. The PRT has several concerns about this methodology. First, as noted above, CMS itself recognizes the limitations of the original data analysis, and the fact that the agency did not make a one-to-one comparison to the PFS rates. We are also concerned by the fact that CMS utilized professional physician claims with a Place of Service 22 (Outpatient Department, OPD). The PRT is confused by

the fact that CMS did not utilize Place of Service 11, which indicates that the services occurred in the physician's office, in its analysis and comparison of costs. The PRT is concerned that CMS has utilized data that do not include the overhead costs of services provided in a physician's office. Instead, CMS is utilizing the cost of overhead (i.e., lower practice expense RVUs) when considering services provided in an outpatient department. We submit that only a small part of the applicable claim scenarios has been considered for determining the actual cost of providing services. Ultimately, the PRT believes that CMS needs to analyze a variety of claims with combinations of services including modifiers PO (excepted off-campus PBD) and PN (non-excepted off campus PBD), and claims with various Place of Service codes (e.g., 22, 19, and 11) in order to have the full picture and more complete data for this analysis.

We are further puzzled by the fact that, for the CY 2017 payment, CMS generated the 50 percent adjustment after reviewing the top 25 codes reported with modifier –PO. CMS' proposed additional reduction is based *solely* on comparing payment for HCPCS code G0463 to the difference between the facility vs. non-facility payment for an E/M service under the MPFS. We fail to understand why CMS' analysis for CY 2017 included the top 25 codes— including both procedures and visits — yet, CMS' current proposal is based on *visit codes* only. The end results is that CMS has a flawed understanding of actual practice.

For example, one PRT member who represents a very large facility pulled data on service types for five of its hospital-based clinics: Gynecology, Internal Medicine, Oncology, Physical Medicine/Rehabilitation, and Chronic Pain Management. The volumes, presented in the table below, clearly illustrate that patients who are seen in various clinics receive services that extend far beyond clinic visits. Certain clinic settings, such as an oncology clinic, provide far more procedures than visits. For this reason, by excluding procedures in its methodology, CMS would systematically disadvantage these types of clinics and the patients they treat— this is inappropriate. (Note that many, but not all, of the services paid in the physical medicine/rehabilitation clinic are paid under the MPFS; we included this clinic type because it represents the highest volume of services for this hospital.)

Clinic Type	**Procedures**	**% Procedures**	**E/M**	**% E/M**	**Total**
Gynecology	2093	24%	6541	76%	8634
Internal Medicine	2093	5%	36157	95%	38250
Oncology	40271	83%	8438	17%	48709
Physical Medicine/Rehab	3043	55%	2473	45%	5516
Chronic Pain Management	1788	38%	2910	62%	4698
Total	**49288**	47%	**56519**	53%	105807

- The PRT urges CMS to base its future analysis on the top 25 reported codes, including *procedures* performed, given the data above and CMS' own methodology used for CY 2017.

We also note that there are certain procedures that are typically performed in off-campus hospital based departments, such as urgent care centers, and are *not* typically performed in a physician office.

For example, many hospitals have established off-campus provider-based departments to respond to a vast array of community health needs. One example is provided by urgent care centers, which fill the gap between services available on a scheduled basis at physicians' offices and emergency services available at a dedicated Emergency Department (ED). Patients can access extended hours and walk-in care at such off-campus sites, thereby obtaining health care services to treat minor illnesses and injuries without either delaying care until a physician office appointment can be arranged or visiting a busy ED for treatment of a minor condition. Additionally, many services provided by urgent care centers are typically *not* offered in physician's office (i.e. immediate care for minor illnesses and injuries, including sprains, strains, cuts, and simple wounds).

In examining our data from PRT member facilities, and comparing our off-campus locations with our hospital-owned physician practices, we see this same trend. Certain types of procedures, including those that are typically more complex and require more infrastructure, are never performed in a physician's office. This illustrates the fact that it is reasonable that hospitals would have higher costs and should receive greater reimbursement.

For this reason, the PRT does not support CMS' continued expectation of, and pursuit of, site neutral payment. CMS must recognize that some site-of-service differential is acceptable and necessary. We believe that any further payment reductions implemented by CMS are likely to result in closures of urgent care clinics, reducing patients' options for accessing health care services in appropriate settings. It will ultimately increase the demands placed on EDs for the types of services that are typically handled in urgent care centers.

If the agency seeks to promote site neutrality for POS 19 (Off-Campus-Outpatient Hospital) and POS 11 (physician's office), the PRT encourages CMS to review and compare procedures performed in those two settings. CMS should then use claims analysis to determine whether or not an adjuster is needed for procedures that are always performed in a physician's office. If equitable payment is truly the agency's objective, the subsequent step would be for CMS to identify CPT-coded procedures that *never* occur in POS 11 and exempt these procedures from any payment reduction. No payment differential exists for these services, since they are never done in a physician's office.

- The PRT recommends that CMS compare procedures performed in POS 19 to those performed in POS 11 and use claims analysis to assess the need for an adjuster for procedures that are always performed in a physician's office.
- The PRT encourages CMS to exempt from payment reduction all CPT-coded procedures that *never* occur in POS 11, since these procedures have no payment differential with the physician office.

The PRT attempted to compare our database to the Medicare National Aggregate HCPCS file from CY 2015 for Place of Service "O" (non-facility). This file includes and lists services from other entities and is based on Medicare's definition of "O" as: "*Identifies whether the place of service submitted on the claims is a facility (value of 'F') or non-facility (value of 'O'). Non-facility is generally an office setting; however other entities are included in non-facility."* The PRT is concerned that we have found inpatient-only procedures listed on this file, such as CPT 35656. The file clearly contains erroneous information; for this reason, we believe it is not useful for this analysis and will hamper any useful comparison.

We believe that further data analysis is needed on the procedural aspect of this proposal. We also believe that a different payment adjudicator or default to the OPPS schedule would more accurately reimburse hospitals for procedures that are not performed in a physician office. We note the clear benefit to beneficiaries of being able to provide such procedures and services in the community.

- The PRT urges CMS to conduct further data analysis on the proposal's procedural aspects.

Finally, the PRT requests a technical clarification regarding the National Uniform Billing Committee (NUBC) requirement to report the locations address in form locator 1 of the UB-04 when a patient is seen/treated in multiple locations on the same date of service. For example, if a patient is seen in a POS 19 in the morning and at the hospital in the afternoon, which location address should be included in form locator 1? If clinics have individual addresses and the patient is seen in multiple locations on the same date, which of the addresses is to be reported?

- The PRT requests that CMS provide a technical clarification regarding the National Uniform Billing Committee (NUBC) requirement to report the locations address in form locator 1 of the UB-04 when a patient is seen/treated in multiple locations on the same date of service.

Evaluation & Management (E/M) Guidelines and Care Management Services

The PRT applauds CMS for seeking to reduce physicians' clinical and administrative burdens and improve documentation requirements to make them more relevant to clinical work-flow and Electronic Health Records (EHRs). In the existing Evaluation and Management (E/M) documentation guidelines, physicians are required to document the following key components for each patient visit, in order to establish the level of E/M service provided:

- History of Present Illness (HPI)
- Physical Examination (Exam)
- Medical Decision Making (MDM)

CMS seeks comments about whether it should reevaluate the requirement to document HPI and review of systems. The PRT agrees that the current E/M documentation guidelines, which are 20 years old, are no longer relevant. We believe that the system, as currently defined, is administratively burdensome and outdated. The guidelines do not reflect the widespread current use of EHR and team-based care that is increasingly used by physicians to support clinical decision-making and patient-centered care.

The PRT agrees that some form of HPI is required for each level of care, and for every type of E/M encounter. While it is important to describe the status of the symptoms and/or clinical problems, we believe the elements of the Past Family and Social History items may not be relevant for every patient seeking services. Further, the current requirement for the review of systems forces physicians to document a specific number of bullets rather than the specific elements needed to describe the patient's clinical situation. The MDM is arguably the most important of the key components and reflects the intensity of the cognitive work performed by the physician. The PRT believes that the MDM is the key determinate of the complexity of services for establishing an E/M.

We support CMS's proposal to restructure the E/M requirements for HPI and Physical Exam. We

recommend that CMS eliminate these elements' required use. We suggest that a better process would be to use CPT code guidelines to document the patient's history, physical examination, clinical picture, and general consistency with the MDM. This process enhances clinical decision- while not creating administrative burden for physicians and facilities.

- The PRT supports CMS's proposal to restructure the E/M requirements for HPI and Physical Exam, and recommends that the agency eliminate the required use.
- The PRT recommends that CPT code guidelines be used to document the patient's history, physical examination, clinical picture, and general consistency with medical decision-making.

Given that CMS acknowledges the guidelines are outdated, burdensome, and irrelevant to current clinical process and patient care needs, the PRT asks the agency to immediately suspend and end any E/M audits in which its contractors are engaged. It makes no sense for CMS to continue holding clinicians accountable to these guidelines and proceeding with audits, when the agency views the guidelines are being appropriate for either elimination or wholesale revision.

- The PRT requests that CMS immediately suspend and end any E/M audits in which its contractors are engaged.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The PRT understands and acknowledges that the utilization of Appropriate Use Criteria (AUC) for advanced diagnostic imaging services is a statutory requirement. The proposals, if finalized, however would present both rendering and furnishing providers with enormous operational burdens. The additional burden to implement this program directly conflicts with the Administration's desire to reduce administrative burden, which is why comments were requested about ways to promote Administrative Simplification. To that end, the PRT has submitted comments that request the elimination of the AUC.

If CMS is forced to proceed with the implementation of AUC, the PRT strongly recommends that the voluntary reporting period of AUC for advanced diagnostic imaging services be extended though end of CY 2019. This will give providers two years to implement the reporting activities. Additionally, we encourage CMS to start its education and operational testing period in CY 2019, continue it through CY 2020, and begin mandatory reporting no earlier than CY 2020. We have also provided this recommendation to the House of Representatives' Ways and Means Committee, as part of our feedback on the Committee's "Red Tape Reduction" project.

- The PRT strongly recommends that the mandatory use/implementation of AUC for advanced diagnostic imaging services be delayed to at least CY 2020, and that there be no payment impact to providers before CY 2020.
- The PRT encourages CMS to expand the voluntary reporting period through the end of CY 2019, begin its educational and operational testing period in CY 2019, and continue this period through CY 2020.

The PRT supports a program by which health care providers can collaborate on the appropriateness of care, transparency, and quality improvement. We greatly appreciate CMS' willingness to

consider our comments during this rulemaking cycle. In the CY 2018 Proposed Rule, CMS presents proposals to continue AUC implementations, as mandated by the Protecting Access to Medicare Act (PAMA). The CY 2016 PFS Final Rule addressed the initial component of implementation, to specify applicable AUC; the CY 2017 PFS Final Rule addressed an additional second component, to specify qualified clinical decision support mechanisms (CDSMs).

In the CY 2018 Proposed Rule, CMS includes proposals related to consultation by the ordering professional, reporting by the furnishing professionals, and alignment of AUC with other Medicare quality programs. Below, we detail our concerns about the following issues:

1. The ability of the rendering providers to obtain the required AUC consultation information from the ordering provider and educating ordering professionals on the AUC requirement.
2. Situations where AUC consultation must be obtained, and G-codes and modifiers reported, when the situation is clearly one that the statute excludes.
3. Reporting AUC consultations when the interpreting physician makes a determination to furnish a different or additional test.
4. The risk of future reviews and potential denials of payment for tests reported with the modifier indicating the imaging service does not adhere to the consulted AUC.
5. AUC consultation requirements for claims determined after-the-fact to be ineligible for inpatient Part A coverage, or for claims where inpatient Part A coverage does not exist.

1. The ability of the rendering providers to obtain the required AUC consultation information from the ordering provider and educating ordering professionals on the AUC requirement.

In the CY 2018 PFS, CMS proposes that, for applicable services ordered on or after January 1, 2019, the ordering professional must consult a CDSM, and the furnishing professionals must report information on the claim related to the ordering professional's CDSM consultation. CMS designated the extended implementation period in response to providers' concerns about the extensive time needed to incorporate changes into facility processes and computer systems. CMS also proposes an educational and operations testing period, during which ordering professionals would consult AUC and furnishing professionals would report AUC consultation information on the claims. During this period, CMS would continue to pay claims whether or not this information was correctly included.

The PRT appreciates CMS' consideration of the challenges this program presents to providers; we support the extended implementation timeframe. With respect to the length of the educational and operations testing period, the PRT supports beginning it in CY 2019 and then extending it through CY 2020. We suggest that, should issues arise that cannot be sufficiently addressed, the education and operations period be extended even longer. The PRT also recommends that, during this period, CMS conduct listening sessions to understand providers' challenges and concerns with program implementation.

- The PRT recommends that the educational and operations testing period should last through CY 2020.
- The PRT urges CMS to conduct listening sessions with both ordering clinicians and furnishing providers during the initial implementation requirement, to understand the challenges ordering clinicians and furnishing providers are encountering.

2. Situations where AUC consultation must be obtained, and G-codes and modifiers reported, when the situation is clearly one that the statute excludes.

CMS specifies that the AUC reporting requirement will apply to applicable imaging services ordered on or after January 1, 2019. The PRT notes, however, that "order date" is not a data element that is currently reported on claims. For example, a test may be ordered by a physician in December 2018, but not provided to the patient until after January 1, 2019 (i.e., after the program implementation date). For purposes of the reporting requirement, it is unclear what claim field would be used to determine which AUC-related data elements are required (if any), or if providers should include some other element (i.e., a modifier) to indicate that the order date preceded the effective date.

The PRT recommends that, in order to avoid inappropriate claim denials, CMS should specify a mechanism that enables providers to indicate that the service was ordered prior to the requirement's effective date. This could be accomplished by using the G-code proposed for use when an AUC consultation was not obtained and a modifier indicating the order date preceded the effective date. This modifier could be retired after sufficient time has elapsed to allow for proper claims processing — for example, one year after the effective date for claim denials if the information is missing.

- The PRT recommends that CMS provide instructions related to orders written prior to the effective dates (i.e., reporting and denial) of the requirement, when the service is provided after the implementation of the AUC reporting requirement's two phases.

The information regarding the AUC consultation that must be reported (on both the technical and professional claim) for services ordered on or after January 1, 2019 is:

1) Which qualified CDSM was consulted by the ordering professional;
2) Whether the service ordered would adhere to specified applicable AUC, would not adhere, or whether the AUC were not applicable to the service ordered, and
3) The ordering professional's NPI.

The PRT has had, and continues to have, serious concerns regarding the reporting requirements, which are detailed below.

The first of our concerns is that the furnishing providers are accountable for reporting information that it must obtain from the ordering provider. In the Proposed Rule, CMS recognizes that the professional who orders an applicable imaging service is not usually the same professional who bills Medicare for the furnished service. This means that the furnishing provider must obtain information regarding the AUC consultation from the ordering provider. The information currently provided to the furnishing provider includes the test being ordered and the related diagnosis.

Under CMS' proposal, furnishing providers would also need to ensure that the order includes the CDSM consulted and the consultation's outcome. If the information is missing, the furnishing provider would have to contact the referring provider to obtain the information. For non-emergency services, any lack of information is likely to result in scheduling delays for the ordered health care services, which will negatively impact beneficiaries. Since the furnishing provider is dependent upon information received from the ordering provider, all information must be properly documented

and authenticated by the ordering provider in case concerns about reporting accuracy arise in the future.

CMS proposes to establish a series of HCPCS level III codes to describe the specific CDSM and code description. To describe a newly qualified CDSM that lacks a specific G-code, CMS proposes to establish a generic code for use until a specific code is developed. A G-code would also be established to identify circumstances in which there was no AUC consultation. A G-code would be required for every advanced diagnostic imaging service on the claim. A series of modifiers would be established to indicate whether the service adheres to AUC, does not adhere to AUC, or an AUC was not applicable. Furnishing providers (such as hospitals) will have little experience with CDSMs. Moreover, the ordering provider's written description may not follow the HCPCS code and modifier's exact descriptions.

- The PRT suggests that CMS define the required information an ordering professional must include related to the AUC consultation on *every* referral/written order to a furnishing provider for the applicable imaging services. The required information must include the HCPCS code for the CDSM and the applicable modifier for the consultation related to the ordered test. This will facilitate entry of the information and assign responsibility for accurate determination of the HCPCS and modifier to the ordering provider. This will also insure the integrity of the data that CMS will receive since the ordering provider has the responsibility of consulting the appropriate AUC.
- The PRT encourages CMS to define what it views as reasonable efforts made by the furnishing provider to obtain AUC consultation information from the ordering provider. CMS should also specify steps that can be taken with respect to rendering the service after those reasonable efforts have been made. (For example, may the furnishing or interpreting provider obtain the AUC consultation on behalf of the ordering provider, using information contained on the order? How should beneficiary complaints regarding delay of service be handled?)
- The PRT recommends that CMS clarify how, on claims with multiple lines of applicable services, the AUC consultation will be linked to each individual service.

The PRT also has some concerns about the proposed education and operations testing period, In recognition of the complex communication that must take place to obtain and report the CDSM consultation, CMS established an education and operations testing period during the first year of implementation. During this testing period, ordering professionals would consult AUC, and furnishing professionals would report consultation information, but CMS would continue to pay claims whether or not they correctly include such information.

The PRT appreciates CMS' recognition of the challenges this program presents, especially to furnishing providers. In addition, we note that failure to have the required information available when a service is scheduled will likely result in delayed treatment for beneficiaries, and financial losses for providers that provide services but lack the information needed to file a claim. The education and operations testing period will help with the transition; in addition, we encourage CMS and its contractors to provide direct communication encouraging ordering physicians to comply with the program.

The PRT recommends using a G-code to identify circumstances where no AUC consultation could

be reported, and establishing a modifier that indicates the ordering provider did not report an AUC consultation to the furnishing provider. CMS or its contractors should then track and trend the use of this code and modifier combination to identify ordering providers who need focused communication about this requirement.

- The PRT believes that CMS should use the education and operations testing period to identify ordering providers who may not be adhering to the AUC consultation requirement, and then provide focused outreach and education activities to these providers.
- The PRT encourages both CMS and its contractors to provide direct communication encouraging ordering physicians to comply with the program.
- The PRT recommends that CMS use a G-code to identify circumstances where no AUC consultation could be reported, and establish a modifier to indicates the ordering provider did not report an AUC consultation to the furnishing provider.
- The PRT suggests that CMS (or its contractors) track and trend the use of the code and modifier combination to identify ordering providers who need focused education about this requirement.

The PRT has concerns about CMS' proposal to establish a G-code to identify circumstances where there was no AUC consultation. The code description would indicate that the ordering provider did not consult a qualified CDSM. CMS proposes to use a modifier when the imaging service was ordered for a patient who has an emergency medical condition (EMC).

The PRT is also very concerned about the impact of the AUC requirement on Emergency Department (ED) operations. The Emergency Medical Treatment and Labor Act (EMTALA) requires hospitals with EDs to provide a medical screening examination to any individual who comes to the ED and requests such an examination. EMTALA also prohibits hospitals with EDs from refusing to examine and/or treat individuals with an EMC.

To meet these requirements, hospitals assume that *all* patients presenting at the ED have an EMC. Providers can only determine whether an EMC exists or not *after* the medical screening examination has been completed. The medical screening exam may or may not include the use of advanced imaging services. In some cases, the presence of an EMC may remain unclear even after the examination; these patients are likely to be placed in observation (as opposed to inpatient) to determine the appropriate level of care needed. In the CY 2017 MPFS Final Rule, CMS advised that exceptions granted for individuals with an EMC included instances where an EMC is suspected, but not confirmed. In the CY 2018 Proposed Rule, CMS proposes the use of a G-code and modifier when the imaging service was ordered for a patient with an EMC, but does not propose a modifier for situations when an EMC is suspected, but not confirmed.

- The PRT recommends that CMS define the proposed modifier to be used when an AUC consultation is not made due to the presence of an EMC condition such that it includes a suspected EMC as well.

CMS proposes that a modifier be reported when the ordering professional has a significant hardship exception.

Significant hardship exceptions will be granted to ordering professionals for circumstances that

include insufficient Internet connectivity, extreme and uncontrollable situations, and lack of face-to-face patient interaction. For these providers, the furnishing provider must still report a G-code and modifier on the claim, indicating that no AUC was consulted due to a significant hardship exception. The PRT is concerned that a provider that has been granted a significant hardship exception may fail to provide the appropriate G-code and modifier to support this exception on the order. The PRT strongly encourages CMS to create some type of identifier for providers that have obtained a hardship exception and that there be a public record of these providers including the initiation and discontinuation dates for the exception. Without some sort of identification system, furnishing providers are at a huge disadvantage in knowing whether a hardship exception exists. Current operational processes are negatively affected when an ordering provider does not provide all the information required on an order. To ask furnishing providers to rely on data that cannot be validated will negatively affect provider reimbursement. The furnishing provider is the provider that is held accountable for services billed to Medicare so a method of validation is required in order to insure compliant billing and performance of services.

- The PRT suggests that ordering providers that have been granted significant hardship exceptions be required to include the appropriate G-code and modifier on orders for advanced imaging services.
- The PRT encourages CMS to create some type of identifier for providers that have obtained a hardship exception and make public information about these providers, and their initiation and discontinuation dates for the exception.

3. Reporting AUC consultations when the interpreting physician makes a determination to furnish a different or additional test.

In certain situations, interpreting physicians may furnish different or additional tests. Medicare describes situations where this may occur in Benefit Policy Manual 100-02, Chapter 15, Sections 80.6.2, 80.6.3, and 80.6.4. For example, unless it is otherwise specified in the order, an interpreting physician may determine, for a patient who is not a hospital inpatient or outpatient, testing parameters without notifying the treating physician. (These parameters might include number of views, thickness of sections, use/non-use of contrast media, etc.) If the treating physician cannot be reached to change an order or obtain a new order, the testing facility may furnish additional diagnostic tests in certain circumstances, such as when delaying the tests would adversely affect the beneficiary, or when the initial test results indicate additional tests are medically necessary. Furthermore, the furnishing facility may discover that a patient has a contraindication that prohibits performing a certain test (i.e., CT with and without contrast cannot be performed due to an allergy to contrast, so only the CT without contrast is performed).

If the interpreting physician performs additional or different tests according to the guidelines, the CDSM consultation that was performed by the ordering physician may not align with exact test that was performed. The PRT is unclear about what steps providers should take in situations when the interpreting physician performs tests different than those that were originally ordered.

- The PRT requests CMS to provide guidance about situations when the interpreting physician performs different or additional tests than those ordered, in accordance with the guidance in 100-02, Chapter 15, Sections 80.6.2 – 80.6.4.

4. The risk of future reviews and potential denials of payment for tests reported with the modifier indicating the imaging service does not adhere to the consulted AUC.

CMS proposes a modifier to report when the imaging service does not adhere to the consulted AUC. This modifier will be used when a CDSM consultation was obtained but the result for the clinical scenario presented does not meet evidence-based guidelines for that scenario. Information regarding the CDSM consulted and the outcome of that consultation are to be reported by the furnishing provider on the claim submitted for payment.

The PRT is concerned that claims submitted with a modifier that indicates the clinical scenario does not meet the evidence-based guideline may lead to future claim review and denial of claims by post-payment contractors. We note that 42 U.S.C. 1395y(a)(1)(A) states:

> Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services—(1)(A) which, except for items and services described in a succeeding subparagraph or additional preventive services (as described in section 1395x(ddd)(1) of this title), are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

The PRT is concerned about the relationship between a CDSM consultation in which the clinical scenario does not meet evidence-based guidelines, reporting the information on a claim, and the potential accusation that a provider knowingly billed for medically unnecessary services. We are unsure if a CDSM consultation with a "does not adhere" result precludes a furnishing provider from billing that service, and if this situation would trigger Advance Beneficiary Notice requirements. We are concerned that future reviews from Recovery Audit Contractors, the Office of Inspector General, and/or CERT contractors may expose providers to financial losses and sanctions. These reviews could be conducted by data mining for claims with the modifier indicating the AUC criteria were not met.

- The PRT recommends that CMS clarify that a CDSM response indicating an ordered imaging service does not adhere to AUC criteria does not necessarily imply that the services were not medically necessary and reasonable.

- The PRT urges CMS to prohibit post-payment reviews based upon AUC criteria not being met for a specific imaging service.

5. AUC consultation requirements for claims that are determined after-the-fact to be ineligible for inpatient Part A coverage or for claims where inpatient Part A coverage does not exist.

Section 1834(q)(4)(C) of the Social Security Act provides certain exceptions to the AUC consultation and reporting requirements. One of these exceptions includes inpatient services paid under Medicare Part A. For planned admissions, it is generally known whether the patient will be an inpatient paid under Medicare Part A. For emergency admissions, however, it is not always known in advance whether the beneficiary's stay will qualify for inpatient Medicare Part A coverage, or if it will be submitted for payment under the Medicare Part B benefit (either as outpatient or inpatient stay). For this reason, hospitals review cases in which the physician orders inpatient services to determine if the medical record documentation supports billing under Part A. If the documentation

is deemed to be insufficient for inpatient Part A, the hospital may determine that it supports billing as either inpatient or outpatient under Part B. In this scenario, services ordered during the inpatient stay would *not* have been subject to the AUC consultation requirement — so there would be no consultation information available to report on the Part B claim. Other scenarios in which a claim may be billed as inpatient Part B include beneficiaries who are not covered by Part A and beneficiaries whose Part A benefits have been exhausted. In these situations, it would not be apparent to the ordering provider that an AUC consultation is required.

There are four options to consider in these scenarios. First, the hospital could obtain AUC consultations on all advanced imaging services ordered for hospital inpatients. This process, however, would create an unreasonable burden for ordering providers. Second, the hospital could contact the ordering provider to request an AUC consultation after-the-fact. This would also present an unreasonable burden for the ordering provider. Additionally, the results of any consultation obtained after-the-fact could be influenced by information that was unavailable when the service was ordered. For example, perhaps the advanced imaging service was instrumental in identifying a condition that was not suspected at the time of the order.

Third, CMS could allow furnishing providers to obtain the AUC consultation after-the-fact. As above, however, the results of any consultation obtained after-the-fact could be influenced by information that was unavailable at the time the service was ordered. (For example, the advanced imaging service could be instrumental in identifying a condition that was not suspected at the time of the order.) As a result of this risk, option three is not optimal, although it would allow the furnishing provider to obtain the information needed to obtain payment for the services it provided.

The fourth option, and the one the PRT recommends, is for CMS to exempt from the AUC consultation requirement all claims for services that are determined to be ineligible for inpatient Part A coverage. We note that the AUC consultation requirement will complicate the already-complex process hospitals have to undergo in order to review claims and determine the appropriate billing classification. The PRT thinks it is quite likely for advanced imaging services to be ordered during a patient stay that the beneficiary's physician believed met inpatient status requirements. The ordering professional has no way to know if the patient lacks Part A coverage (either due to ineligibility or the exhaustion of benefits) and the subsequent need for AUC consultation for advanced imaging services. Further restricting the payment received by the interpreting physician and the hospital increases both entities' financial burden in providing services to the Medicare population.

- The PRT recommends that CMS exempt, from the AUC consultation requirement, claims for services that are determined, after an AUC-related service has been provided, to be ineligible for inpatient Part A coverage. This would include claims billed as inpatient Part B and claims that were improperly assigned inpatient status and later billed as outpatient, when an appropriate order is present.

Clinical Quality Measurement for Eligible Professionals Participating in the Electronic Health Record (EHR) Incentive Program for 2016

CMS proposes to change the reporting criteria for Eligible Professionals and groups who chose to electronically report Clinical Quality Measures (CQMs) through the Physician Quality Reporting

System (PQRS) portal for purposes of the Medicare EHR Incentive Program. To align reporting requirements between the Medicare EHR Incentive Program and the final PQRS reporting period, CMS proposes to change the criteria for these providers from nine CQMs covering at least three National Quality Strategy (NQS) domains to six CQMs with no domain requirement. This proposed change is intended to help avoid redundant or duplicative reporting as required under Section 1848(o)(2)(B)(iii) of the Social Security Act.

The PRT appreciates CMS' efforts to reduce and avoid redundant or duplicative reporting. Such changes are important to support efforts to reduce providers' administrative burdens.

Value-Based Payment Modifier and Physician Feedback Program

The Value-Based Modifier (VM) authorized under the Affordable Care Act (ACA) provides bonus payments, penalties, or a neutral adjustment (i.e., no bonus or penalties) to physician's Medicare fee-for-service payments based on the quality and cost of the care provided. CMS will apply the VM to all physicians. To avoid VM penalties in CY 2018, physicians must have participated in the PQRS in CY 2016. Lack of successful participation in the PQRS program in CY 2016 will result in a two percent PQRS payment penalty and may result in additional penalties up to 4 percent under the VM. Solo practice physicians and groups up to nine physicians will avoid VM payment penalties, but may see bonus payments; penalties; or a neutral adjustment (no bonus or penalty). Groups of 10 or more providers will be subject to those payments or penalties.

For the CY 2018 payment year, CMS proposes to change the current PQRS program policy that currently requires reporting nine measures across three National Quality Strategy domains. Instead, CMS would only require reporting of six measures for the PQRS. This is significant for the many practices that have previously struggled to reach the higher threshold. The PRT supports this change and believes that it will also eliminate the provider burden by reducing the required reporting of three additional measures.

In addition, CMS proposes to ease downward adjustments in the value-based payment modifier. The agency's proposal reduces the automatic downward payment adjustment applied for not meeting minimum quality reporting requirements from negative four percent (-4%) to negative two percent (-2%) for groups of 10 or more clinicians. It reduces the adjustment from negative two percent (-2%) to negative one percent (-1%) for physician and non-physician solo practitioners and groups of 2 to 9 clinicians.

The proposal would also hold harmless all physician groups and solo practitioners that met minimum quality reporting requirements from downward payment adjustments for performance under quality-tiering for the last year of the program. CMS also proposes to align the maximum upward adjustment amount to two times the adjustment factor for all physician groups and solo practitioners. The PRT applauds CMS in their efforts to streamline the Value-Based Payment Modifier program in the proposed manner.

MACRA Patient Relationship Categories and Codes

The PRT applauds CMS' continued focus on improving health outcomes, spending in a more efficient and effective way, reducing participation burdens, and improving fairness and transparency in operations. We also understand that CMS is shifting its payment system to the cost-based Merit-

based Incentive Payment System (MIPS), and that the agency must, therefore have a way to attribute costs to different providers. We further understand that the use of modifiers to describe the physicians' relationship with patients is a statutory requirement under The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

While we understand the rationale of utilizing modifiers to indicate patient relationships, the PRT is concerned about the approach proposed by CMS. Using modifiers to define physician services is a challenge, and adding additional modifiers has the potential to increase both administrative burden and costs for physician practices. If CMS moves forward with this proposal, providers will need significant time to operationalize it and train both physicians and other staff. At the same time, CMS will need time to collect and analyze data on these relationships.

We appreciate, and support, CMS' statement that payment will not be impacted by the use (or non-use) of these modifiers until education, operationalization, and data collection has occurred. Yet, we are concerned that, if the program is voluntary, participation will be low and CMS will be hampered in its ability to collect the very data needed to create payment levels.

To address these challenges, we recommend that CMS clarify whether the program is voluntary or mandatory at the present time. CMS should also establish a time-frame during which the modifiers are required in order to facilitate data collection and analysis. Since this proposal will impact physician reimbursement in CY 2020-2021, we suggest that the time frame for voluntary reporting be (January 1, 2019 through December 31, 2020) with mandatory reporting beginning January 1, 2021.

- The PRT recommends that CMS clarify the timeframes during which the proposed modifier use will be voluntary vs. mandatory.
- The PRT urges CMS to create mechanisms by which the agency can receive adequate data to set payment rates, without endangering reimbursement. A one-year window for mandatory data provision without payment impact would provide sufficient time for data collection and analysis, education, implementation, and operationalization.

Proposed Changes to the Medicare Diabetes Prevention Program (MDPP) Expanded Model

The PRT supports the Medicare Diabetes Prevention Program (MDPP) proposal to continue to test a method to help beneficiaries preventing the onset of Type 2 Diabetes Mellitus (T2DM). The proposal to delay implementation until the new start date of April 1, 2018 will provide suppliers more time to prepare and enroll beneficiaries, and ultimately help ensure the program's success. We believe that it is reasonable to set the expectation of successful weight loss by limiting the duration of ongoing maintenance sessions that are covered by MDPP services to two years. We also support CMS' proposal to link some payment to weight loss, and view this as a reasonable component to reducing patients' T2DM risk. The program's success ultimately depends on patient adherence and engagement; for this reason, we support CMS' reduction of financial risk for MDPP suppliers when beneficiaries do not meet weight loss goals. To this end, payments for sessions in the first six months of the program and attendance are fair measures.

Collection of Information Requirements

ICRs Regarding Appropriate Use Criteria for Advanced Diagnostic Imaging Services

To fairly evaluate whether the Office of Management and Budget (OMB) should approve information collection, CMS is soliciting comments on:

- The need for the information to be collected and its usefulness in carrying out the proper functions of the agency.
- The accuracy of the burden estimates.
- The quality, utility, and clarity of the information to be collected.
- Efforts to minimize the information collection burden on the affected public, including the use of automated collection techniques.

The PRT welcomes the opportunity to comment on the accuracy of the burden estimate and efforts to minimize the information collection burden on the affected public, including the use of automated collection techniques.

Accuracy of the Burden Estimate

Our overarching comment is that this program is not cost-effective and should be reexamined. The Congressional Budget Office estimates that Section 218 of PAMA, AUC implementation for Advanced Diagnostic Imaging Services, will result in $200 million in savings over 10 years. Yet, as noted in the Proposed Rule, CMS estimates that there will be a one-time burden solely for ordering providers of *more than $7 million*, occurring just during the voluntary reporting period. CMS further estimates there to be an annual burden of *more than $275 million* thereafter, again, solely for ordering providers. Based on these estimates, the burden of $282 million for the ordering physician alone far exceeds the estimated savings. Just reviewing these estimates causes significant concern on the part of the PRT, and confirms that the program grossly increases operational burdens for ordering providers.

There are two additional and significant cost implications that CMS does not mention, which will increase overall costs even further: the impacts to the rendering and interpreting providers. The PRT estimates that costs will be *exponentially greater* for the rendering and interpreting providers. We are concerned that CMS has not provided any estimate of the costs to these providers. The rendering/interpreting providers must add the HCPCS code and modifier related to CDSM that was consulted. These providers have a far greater burden than the ordering provider, since the required information must be obtained from the ordering provider when the latter fails to provide it, and since, in the future, payment will be denied if the information is not reported. We respectfully request CMS to explain why the estimate costs were not completely assessed, and to provide estimated costs for rendering and interpreting providers.

We understand the purpose of this program is to identify the physicians who are outliers in their ordering of services. The goal is to ensure that diagnostic services are appropriately ordered. Yet, the current proposal targets rendering/interpreting providers (i.e., physicians and hospitals).

Accessing the CDSM is just one part of the AUC. The ordering professional is required to access a CDSM for every Advanced Diagnostic Imaging Service ordered. CMS estimates that it takes two minutes for this task. Once the ordering professional has accessed the CDSM, he or she must provide information about the accessed CDSM, the access' outcome, and the NPI of the ordering

provider. These three new fields are not, however, currently collected on the 837I. On the 837I, the ordering physician is collected once and reported as the attending physician; it is not collected and entered for every line item on the claim.

CMS has not set a requirement for electronic communication of the required information. And, there are no opportunities for the rendering/interpreting provider to obtain information about the AUC consultation, independent of obtaining it from the ordering provider. Rendering and interpreting providers must obtain the information and enter it into their computer systems so that it can be reported on the claim, or payment will be denied. Accurately reporting this information (i.e., the applicable HCPCS code and modifier for each test ordered) to the rendering/interpreting provider via the test order facilitates entering the information. When the ordering provider fails to provide the required information, however, the rendering/interpreting provider cannot process the order, and therefore cannot provide the service and receive payment for the order's execution. The provider's only options are to contact the ordering physician directly, or ask the beneficiary to do so. Either option would certainly require at least a five-minute conversation.

It is difficult to estimate the time it would take for rendering/interpreting providers to enter the information. Likewise, it is difficult to estimate the number of orders that will be received without the required information. Nonetheless, we believe that it will take, on average, more than two minutes for rendering/interpreting providers to comply with AUC requirements. The PRT believes CMS should re-visit its estimate of the impact and include the regulatory burden for rendering/interpreting providers.

- The PRT recommends that CMS re-visit its estimate of the impact to include the regulatory burden to rendering/interpreting providers, and publicize the resulting estimate to the provider community.

Minimization of Information Collection Burden

The PRT appreciates the opportunity to comment on efforts to minimize the information-collection burden on the public, including the use of automated collection techniques. CMS has not established any automated reporting requirement for CDSMs. The only automated reporting requirement CMS established is from the rendering and interpreting provider to CMS. In an age of EHRs, CMS should require CDSMs to interact with EHRs to report the information needed regarding the CDSM consultation.

- The PRT encourages CMS to require CDSMs to interact with EHRs in order to report the information needed regarding the CDSM consultation.
- The PRT urges CMS to find another method for capturing this information rather than putting such an enormous burden on rendering/interpreting providers.

Conclusion

The PRT appreciates the opportunity to provide comments on the CY 2018 MPFS Proposed Rule. We encourage CMS to continue to work with physicians and their professional societies through the rulemaking process in order to create a stable and equitable payment system.

If you have any questions or comments on this letter, please contact Ms. Terri Rinker at 765-298-2110 or via email at: Terri.Rinker@ecommunity.com

Attachment A: Provider Roundtable Members

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Updated August 2017