
September 9, 2018

*Atrium Health (NC, SC)*

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

*Baptist Health South Florida (FL)*

*Community Hospital Anderson (IN)*

*Franciscan Missionaries of Our Lady Health System (LA)*

*Hartford Healthcare (CT)*

*Hardin Memorial Hospital (KY)*

*Kaiser Permanente, Southern California Permanente Medical Group (CA)*

*SSM Health (IL, MO, OK, WI)*

*University of Pittsburgh Medical Center (PA, NY)*

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

Re: CMS-1693-P

Dear Ms. Verma,

The following comments are submitted by the Provider Roundtable (PRT), a group composed of providers who gathered to generate comments on the CY 2019 Medicare Physician Fee Schedule (MPFS) Proposed Rule, as published in the *Federal Register*.

The Provider Roundtable (PRT) includes representatives from 13 different health systems, serving patients in 20 states. PRT members are employees of hospitals. As such, we have financial interest in fair and proper payment for hospital services, 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 OPPS 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:

E/M Documentation Guidelines

- The PRT encourages CMS to coordinate with non-Medicare payers to determine if they will agree to a change in documentation requirements**.**
- The PRT recommends that CMS work with the AMA to facilitate changes to the CPT guidelines/instructions in order to allow actual changes to the documentation requirement.
- The PRT recommends that CMS not collapse the five visit levels into a two level payment structure as the proposal does not reduce any documentation burden for providers.
- The PRT requests that CMS perform further claims analysis to determine the frequency that multi- specialty practice visits would be impacted before moving forward with the payment reduction for a visit and procedure on the same day.

Appropriate Use for Advanced Diagnostic Imaging

- The PRT recommends that CMS clarify that the proposal contained in the 2019 MPFS proposed rule would allow auxiliary personnel, as well as clinical personnel, to perform the AUC consultation under the direction of the ordering professional and incident to the ordering professional's services.
- The PRT recommends that CMS establish a methodology for situations where an AUC consultation was not performed and that these situations include 1) modification and/or addition of ordered test(s) in accordance with Medicare publication 100-02, Chapter 15, Sections 80.6.2-4 and 2) changes made to comply with the requirements for billing under the appropriate setting, i.e. inpatient vs. outpatient. This could be handled through the use of a modifier or included as a hardship exception or by allowing AUC consultation by the furnishing professionals after the service has been rendered.
- The PRT recommends that CMS limit AUC consultation reporting to avoid duplication of reporting and unnecessary burden to providers. This limitation should be according to the definition of furnishing professional as specified in 1834(q)(1)(F) of the Social Security Act as follows: FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term `furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service.
- Regarding claims-based reporting, the PRT recommends that CMS provide more specific details on how the G-codes and modifiers will be used to meet the requirements of AUC consultation reporting for each service line submitted on the claim.
- Absent timely provision of specific information related to the claim reporting requirements, the PRT recommends that the educational and operational testing period be continued through calendar year 2020.
- The PRT recommends that CMS limit the claim-based reporting requirement to services reported on the 1500 claim form in order to facilitate the implementation.
- The PRT recommends that CMS specify that documentation to support a hardship exception must be maintained by the ordering professional.
- The PRT recommends that CMS recognize hardship exceptions that may impact the furnishing providers.

- The PRT recommends that CMS consider implementing the AUC program on a smaller scale in order to assess and truly understand the benefit(s) of the program. A limited approach would allow for controlled implementation in order to completely and thoroughly analyze data that reflects the true cost and benefit to both providers and CMS.

***E/M Documentation Guidelines***

The CY 2019 MPFS proposed rule contains the most significant changes to E/M documentation and payment proposed to date and the PRT understands CMS' rationale is to allow more flexibility, eliminate burden, and recognize the role of EMR & technological capabilities and the changing practice/nature of medicine. We appreciate CMS' desire to help to reduce the administrative burdens for physicians and other health care professionals so that they can devote more time to patient care. The proposal purports to reduce current aspects of documentation which are redundant or outdated but we disagree that these key elements will achieve what CMS believes the desired outcome will be. The PRT submits that CMS' proposal to change the documentation requirements and collapse the current five levels of E/M into two will not reduce any burden on providers but in fact will create more of an administrative burden. Providers must continue to document in the same manner and to the same level of detail because of requirements by other payers. Providers treat patients in their office without knowing which payer is involved; the provider renders the same care and evaluation/management for each patient regardless of payer. Therefore, the provider must continue to document in the current manner. The proposed changes will negatively impact providers as it will create dual types of documentation requirements lending to provider's confusion of what is required documentation to support the services provided based on the payer source. Furthermore, the AMA is the official source of guidance regarding documentation for the E/M CPT codes according to the Administrative Simplification Act. The PRT believes that CMS's proposal is not truly a change in the documentation requirements, but is actually a change to documentation that CMS will accept in order to support an E/M level, which in the end supports the reimbursement received by the provider.

While the PRT applauds CMS' desire to alleviate documentation burden on providers, the PRT has very serious concerns regarding other elements of CMS' proposals and provide comments on the following:

- Implementation start date: 2019 vs. 2020
- Whether the proposals will reduce clinician burden
- Whether certain proposals will impact program integrity/create unintended consequences
- CMS notes it is proposing a broad outline of changes and anticipates details related to program integrity and ongoing refinement to be developed over time through sub-regulatory guidance

**The PRT wholeheartedly agrees with the following proposals:**

- Elimination of certain documentation requirements for home visits (CPT codes 99341-99350) related to practitioners not having to document the medical necessity of a home visit vs. an office/outpatient visit
- Allow practitioners to document what has changed since the last visit or record only pertinent items that have not changed, rather than re-documenting all information such as review of systems or past medical, family or social history
- Allow practitioners to review and verify information in the record entered by ancillary staff or the beneficiary, rather than re-entering it

- Streamline teaching physician documentation requirements to avoid duplication so that teaching physician involvement can be demonstrated by notes in the medical record made by a resident or nurse
- Eliminating the current prohibition on payment of two E/M office visits billed by a physician of the same specialty from the same group practice for the same beneficiary on the same day unless the visits are for unrelated problems

The PRT's concerns are based on the fundamental flaw with this proposal - the HIPAA transaction set for reporting services is CPT codes. While the Agency did consider this by proposing HCPCS Level II G-codes or Q-codes to support a different level of documentation, HCPCS Level II codes would be applicable only for Medicare. Our providers are payer agnostic to ensure their patients receive the proper level of care regardless of their coverage. Indeed, for facility providers, non-discrimination and the same treatment for all patients regardless of payer is a key tenant to maintain participation in the Medicare program. Therefore, a unilateral change in documentation requirements will provide no decrease in documentation burden for a visit note. However, there are options that would support CMS' initiative and create a decrease in provider burden.

CMS should work with the AMA to restructure the CPT code definitions for E/M visits and create a new standard for documentation components. A single standard would comply with the HIPPA transaction code set requirements and ensure that the relative value is distributed across primary care and specialty providers. A single standard for documentation based on E/M definitions would require all payers to follow CMS' lead in this endeavor. This would standardize and streamline E/M visit level assignment and documentation requirements while reducing confusion among the provider community and reducing provider burden.
CMS requests feedback on timing. The timing for implementation must include consideration of the operational and technological changes that must be made by providers. This is much more operationally challenging than just changing the codes that are reported.
CMS must understand that the electronic health records will have to be updated. Because CPT is the official guidance for these services, electronic records have been created and formatted to encourage documentation based on the existing codes and guidelines. CMS noted in the proposed rule that focusing on specific documentation related to medical decision making or time involved in the visit will be different for certain specialties. CMS can make concessions on which part(s) of the code definition are appropriate for focus by a specialty because they can instruct CMS auditors to focus on the specific documentation related to medical decision making or time. However, non-Medicare payers will continue to require that the provider's documentation supports the full complement of the CPT definition. Based on this reality, this proposal creates no administrative relief – CMS guidance is not authoritative for non-Medicare entities; therefore, other payers will continue to follow CPT definitions/guidelines as the HIPAA transaction set. In order to have this proposal be successful for both providers and CMS, the "new documentation standard" must be married with CPT guidance in order to be applicable across all payers.

**The PRT recommends that:**

1. **CMS coordinate with non-Medicare payers to determine if they will agree to a change in documentation requirements.**
2. **CMS work with the AMA to facilitate changes to the CPT guidelines/instructions in order to allow actual changes to the documentation requirement.**

3. **CMS not collapse the five visit levels into a two level payment structure as the proposal does not reduce any documentation burden for providers.**

**Payment Reduction**

CMS is proposing a payment reduction when an E/M service is provided in combination with a procedure on same day (50% payment of lower service & 100% of higher service). The PRT asks CMS to identify whether the services were related or unrelated based on claims data. Diagnosis codes could be used to determine related or unrelated. There may be circumstances in which a beneficiary is seen for a visit level that is a separate condition from the one for which the beneficiary is having a minor procedure performed in the office.

Furthermore, the rule states that the payment will be reduced for the less expensive of the two services when provided on the same day by the same provider or group practice. While we understand CMS' rationale for consideration when a visit and procedure are performed by a single specialty physician practice, for multi-specialty practices, this language is very problematic. For a multi-specialty practice, a beneficiary may see a cardiology physician and have a procedure in the morning, and then in the afternoon have a visit with a dermatologist for an unrelated matter. Because the cardiologist and the dermatologist reside in the same group practice, is it truly the intention to lower the payment for one of the two? Because these visits are not related in any way, they should not be associated in order to trigger a payment reduction. This policy will cause beneficiary inconvenience and force providers to schedule patients to return on multiple days in order to avoid a reduction in reimbursement due to an unrelated service. We are concerned that this will likely be an unintended consequence, especially when providers have worked so diligently to schedule patients for the patient's convenience. We request that CMS revise the policy to prevent payment reductions when the visits involve providers of different specialties.

**The PRT asks that CMS perform further claims analysis to determine the frequency that multi-specialty practice visits would be impacted before moving forward.**

**Two Payment Levels for E/M visits**

CMS proposes to streamline payment for outpatient/office E/M visit codes (99201-99215) into two levels – payment for a level one visit and then a single payment for levels 2-5 (physician and non-physician in office based/outpatient setting). Each visit level consists of different time involvement and different levels of resource expenditure based on the CPT definition. Providers have created their visit charges based on these differences. The PRT is concerned that providers will feel that they cannot spend long periods of time with patients based on their individual conditions and perform the needed level of assessment to best care for patients. Providers should not feel pressure to reduce time with patients based on a two level payment structure that no longer reflects resources utilized. CMS has long ascribed to "individual care for the individual patient's clinical condition" but is now looking to penalize providers who follow this same mantra.

The PRT has additional concerns regarding the assignment of equal RVUs to CPT codes for levels 2 - 5. Many non-Medicare payer contracts rely on RVUs to determine appropriate payments to physicians. Collapsing the RVUs for these three levels will require a review of

provider contracts and could have unintended and unforeseen impacts on future determinations of fair market value.

**The PRT disagrees with a two level payment system for the reasons noted above.**

**Two E/M visits on the same day**

CMS is soliciting comments on whether a change to current requirements that do not allow payment of two E/M office visits billed by a physician (or a physician of the same specialty from the same group practice) for the same beneficiary on the same day unless for unrelated problems originally intended to reflect multiple visits with the same practitioner, or by practitioners in the same or very similar specialties within a group practice, on the same day as another E/M service would not be medically necessary.

We appreciate CMS recognizing how care is delivered, organized, and how practitioners being in multiple specialties may warrant changes to this policy.

The PRT agrees with and supports a closer analysis of the data from large multi-specialty practices that provide care to patients holistically, in a convenient location, and with all the necessary resources available for good patient care. We believe services provided to patients being seen in these multi-specialty areas are medically necessary, provide patient-centered individual care. These are some of the reasons that larger group practices originated. The PRT supports CMS analysis and supports changes to the current requirements that would allow payment for two E/M office visits on the same date for the same beneficiary.

***Radiologist Assistants***

In response to recommendations received from commenters regarding improving flexibilities and efficiencies under the Medicare program, CMS has proposed to revise the regulations related to the supervision of diagnostic imaging tests. Specifically, CMS has proposed to add a new paragraph to §410.32 to state that diagnostic tests performed by a Registered Radiology Assistant (RRA) or a Radiology Practitioner Assistant (RPA) require a direct level of physician supervision, when permitted by state law and state scope of practice regulations. Otherwise, the diagnostic imaging test must be performed as specified elsewhere under §410.32(b). This change will not affect those services that currently require a general level of supervision.

The Provider Roundtable appreciates CMS's response to stakeholder comments and supports this proposed change. We do note, however, that the revised language states "diagnostic tests" performed by an RRA or RPA and suggest that the language be changed to "diagnostic imaging tests."

In the discussion regarding this change, CMS notes that the required minimum physician supervision level for each diagnostic X-ray and other diagnostic test services is included in the PFS Relative Value File. Providers, both physicians and hospitals, refer to this file to determine the appropriate level of supervision required to ensure patient safety and coverage of specific services. The PRT seeks clarification as to whether the change in §410.32 will result in a change to the physician supervision level indicators contained in the Relative Value File. For example, supervision indicator 03 is assigned to the technical component of CPT code 73040, indicating

that personal supervision is the minimum level of supervision. Pursuant to the change to §410.32, if the minimum supervision level is changed to 02 (direct supervision), the PRT is concerned that providers will not understand that direct supervision applies only when the service is performed by a RRA or RPA. If a change to the supervision level indicators is made, the PRT recommends creation of a new supervision indicator code with language that makes it very apparent that direct supervision is limited to services performed by a RRA or RPA; otherwise personal supervision is still be required.

***Communication Technology-Based Services***

In general, the PRT supports CMS' proposal to cover asynchronous telemedicine. CMS' coverage of these services illustrates that asynchronous telemedicine services are clinically-valid tools through which providers can deliver efficient and patient-centered healthcare services. Because the new virtual care codes utilize asynchronous/non-face-to-face modalities, CMS does not consider them to be "inherently face-to-face services" and notes they would not be "defined, coded, and paid for as if they were furnished during an in-person encounter." CMS has proposed new codes and separate reimbursement under the Physician Fee Schedule.

The PRT understands that "Medicare telehealth services" are services that must ordinarily be furnished in-person, although may be provided using interactive, real-time telecommunication technology. We understand that there are statutory restrictions based on the Social Security Act regarding services that can be considered "Medicare telehealth services." We also understand that currently Medicare telehealth services are limited in relation to geography, patient setting and type of furnishing practitioner.

We are struggling however, in why these services should be considered as "non-Medicare Telehealth Services" when the basic premise is the same. Services are provided to beneficiaries by healthcare providers using telecommunication technology. We submit that the definition of Telehealth Services should be redefined to include these services as well. CMS has stated, and the PRT agrees, that telecommunication and technology-driven methodologies are the ways in which the public, including Medicare beneficiaries conduct not only their business, but their personal lives as well. Technology will continue to become the way for communicating and operating, and healthcare must go along this same path. While we definitely support the creation and payment of these technology codes, we also believe that CMS should work with Congress to see the "larger picture" that is looming, and in that vein, update the regulations that have become a barrier to expansion of telehealth services.

We are pleased to offer responses to additional specific proposals.

**Brief Communication Technology-Based Service, e.g., Virtual Check-In (HCPCS Code GVCI1)**

The PRT supports CMS's efforts to utilize current and future communication technology to facilitate interactions between the physician and other qualified healthcare professionals in non-face-to-face check-in with the patient. We believe this interaction is valuable to the patient and to the provider to assess the patient's conditions and to help guide the patient's decision-making process in terms of seeking the appropriate level of treatment. We further support the definition of the proposed code GVCI1 (Brief communication technology-based service) with regard to services provided to an established patient.

The PRT supports CMS' proposal to reimburse for this level of service and applaud CMS' recognition of the time and intensity invested by the provider(s) to engage the patient with current and future communication technology. Given that CMS recognizes the provider effort, we recommend that the pricing be comparable to the current reimbursement for E/M services. While CMS' current proposal is based on the expectation that the interaction would be initiated by the patient, this could be expanded to include an interaction by the provider for continued evaluation and management of the patient's current condition(s). This would be with the patient's consent for the provider initiated interaction.

**Remote Evaluation of Pre-Recorded Patient Information (HCPCS Code GRAS1)**
The PRT is highly in favor of CMS's proposal regarding patient transmitted information via pre-recorded "store and forward" technology. We further support that these services would not be subject to the Medicare telehealth restrictions in section 1834(m) of the Act as well as CMS' proposal to value the service to reflect the provider's resource cost. The PRT agrees with the proposed code GRAS1 and recommends that CMS recognize the work effort required not only by the provider, but also the technology support personnel to stand-up such platforms and opportunities for the patient to utilize technology. The PRT recommends that CMS reimburse this service based on existing E/M codes. This proposal opens the doors to patients who desperately seek care for dermatological issues with a rapid turnaround time thus easing their concerns because the appropriate medical professional has evaluated their health care condition. This proposal is good for the patient, the provider, and the community at large by providing a solution through current and future communication technology.

**Interprofessional Internet Consultation (CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449)**
The PRT applauds CMS' proposal for separate payment of interprofessional consultations and further supports CMS by recognizing the need to change the focus in medical practice and how to manage chronic conditions for the Medicare population. We recognize the need to support the chronic conditions of the Medicare population through using current and future communication technology. As CMS is aware, many chronic care patients have multiple medical conditions, many of which impede or prevent the patient from being able to make and continue treatment appointments. The proposed change allows the opportunity for that same patient to have the same care, see the same specialist for the chronic condition at another location with another treating provider. While we agree with the proposal and understand CMS' concern, we do not share the concern of needing to distinguish these services "from activities undertaken for the benefit of the practitioner, such as information shared as a professional courtesy or as continuing education." We believe that physicians and other qualified providers recognize their limitations and will use this option as an opportunity to more quickly consult a specialist to benefit the patient, thus providing a better continuum of care for a Medicare beneficiary's chronic condition(s).

**Subsequent Hospital Care Services: CPT Codes**
The PRT agrees with the request to remove the frequency limitation for CPT codes 99231 – 99233 for specialty providers. The PRT urges CMS to recognize that the admitting provider may request an Interprofessional Internet Consultation for the patient, allowing the specialty provider to assist in directing appropriate care for the beneficiary's chronic condition(s). The PRT recognizes that to facilitate this need, the specialty physician would be expected to obtain and maintain appropriate privileges at the originating hospital site where the beneficiary is located. The reporting limitation inhibits the potential need of a specialist to follow the

beneficiary on a more frequent basis when appropriate and necessary. The PRT agrees that the admitting practitioner should continue to maintain in-person visits with the beneficiary. We urge CMS to remove the limitation rule in regard to specialist visits to ensure Medicare beneficiaries receive appropriate specialist care for their chronic conditions through current and future communication technology while in the hospital.

The PRT offers comment on CMS' proposal to add the following codes to the technology-based services list.

***990X0 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, repiratory flow rate), initial; set-up and patient education on use of equipment.***

The PRT applauds CMS' proposal to include remote patient monitoring paramaters as well as recognize the time spent with regard to the supply of devices; set up and instruction; and patient education on the use of the equipment. We believe that this time spent is directly correlated to the patients' success in the program – both from a satisfaction perspective as well as a compliance and engagement perspective. The importance of patient engagement and compliance has a direct correlation for clinical outcomes including reduced readmission rates, reduced length of stay, reduced mortality in the 30-day and 90-day periods.

***990X1 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, repiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days***

The PRT agrees with the addition of 990X1 to the list of technology-based services. Patients who are suffering from chronic illnesses, are homebound, or live far distances from their specialists are better served with the use of remote monitoring. We agree with the AMA's proposals as noted. The PRT believes the availability of this type of monitoring will decrease hospital length of stay, reduce readmissions, and reduce mortality.

***994X9 Remote physicologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.***

The PRT believes CMS has accurately described the length of required time to review patient-entered data that is collected via a remote patient monitoring technology platform. We agree with the AMA's proposals as noted.

**Submitted Requests to Add Services to the List of Telehealth Services for CY 2109**
The PRT supports the addition of HCPCS codes G0513 (*Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes)* and G0514 (*each additional 30 minutes)* to the list of allowable telehealth services.

Based on changes made by the Bipartisan Budget Act of 2018, CMS is proposing to amend their regulations to reflect the required changes in telehealth reimbursements, to commence on Jan. 1, 2019. These changes are specifically related to the treatment of end stage renal disease (ESRD) and acute stroke, and include the following:

***ESRD***
The PRT supports the addition of renal dialysis facilities and the patient's home as Medicare telehealth originating sites, and that neither originating facility fee nor geographic requirement will apply.

***Acute Stroke***
Because the specifics of the proposal regarding telehealth services for Acute Stroke scenarios are a statutory requirement, the PRT supports the creation and use of a modifier to identify these services. We agree this would be the least burdensome method of reporting.

***Global Surgery Data Collection***
CMS notes that CPT code 99024 was utilized by only 45 percent of practitioners who met the criteria for reporting post-operative visits. The PRT recommends that CMS include CPT 99024 as a telemedicine allowable code. This will provide more compliance in closing the loop of the global surgical package.

***Therapy services***

**Outpatient Hospital Therapy and MACRA**
The PRT noted with interest that this proposed rule includes a provision to add Physical Therapists, Occupational Therapists and Speech-Language Pathologists to the definition of a clinician eligible for the MIPS program. The PRT is concerned about the implication to outpatient rehabilitation services provided by hospitals. These services are provided by credentialed professionals under treatment plans ordered by clinicians. The PRT is well aware that payment for these outpatient services is made under the Medicare Physician Fee Schedule (MPFS) payment system even though these services are billed on hospital claims under the hospital's CCN. The designation as a MIPS eligible clinician will be available only to those therapy providers who bill professional services on a 1500 claim form under their individual NPI. Thus therapists employed by hospitals will not have an avenue for participation as they are not required to individually enroll under the Medicare program and their individual NPIs are not reported on hospital claims.

Under the proposal, this renders these therapy providers ineligible for payments above the baseline that are otherwise available between 2020 and 2026 to clinicians performing the same services in freestanding settings. We have questions about outpatient hospital therapy services as we believe it is important to establish a methodology to recognize some type of MIPS or other QPP-type inflationary increases for outpatient hospital therapy services.

The PRT does not believe that it will be administratively possible for hospitals to individually enroll all their employed therapists. We believe CMS recognizes the value of therapy services provided in the outpatient hospital setting and should have the authority to propose an administrative solution that will attribute some type of average MIPS increase to hospitals. Would CMS please address this issue in the Final Rule?

**Appropriate Use for Advanced Diagnostic Imaging**

Throughout the Appropriate Use Criteria (AUC) program implementation process CMS has solicited and considered comments provided by various stakeholders regarding the program. The PRT applauds CMS' collaborative approach and values the opportunity to work with CMS.

**Proposals for Continuing Implementation**

Expanding Applicable Settings

The PRT supports CMS' proposal to add IDTFs to the definition of applicable settings which must meet the AUC consultation and reporting requirements. The PRT agrees that adding IDTFs will apply the AUC program appropriately and consistently across outpatient settings where applicable imaging services are reported.

**Consultations by Ordering Professionals**

The PRT appreciates CMS's attention to the question of who may perform the consultation. The proposed changes partially address those concerns; however, the use of the terms "clinical staff" and "auxiliary staff" should be explored to prevent confusion. In a physician's practice there is a difference between those designated as "clinical" staff and those designated as "auxiliary" staff. Auxiliary staff may include individuals who are not licensed, but perform important functions related to a physician's clinical services. These individuals often possess significant experience and knowledge about the services provided, and often assist in scheduling and preparation for advanced diagnostic imaging tests. Given that CMS wishes to minimize the administrative burden of the AUC program and given that "auxiliary" staff would be providing the consultation incident to the physician's services, the PRT recommends that CMS clarify that the consultation may be performed by "auxiliary" staff, as defined in §410.26(a)(1), under the direction of the ordering professional. That is, "*Auxiliary personnel* means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner), has not been excluded from the Medicare, Medicaid and all other federally funded health care programs by the Office of Inspector General or had his or her Medicare enrollment revoked, and meets any applicable requirements to provide incident to services, including licensure, imposed by the State in which the services are being furnished."

The PRT submitted extensive comments to the 2018 proposed MPFS rule regarding the implementation of the AUC program. CMS' proposal to include auxiliary staff does not address some situations where we believe consultation may not be obtained for the service furnished.

1. Situations where the furnishing professional performs different or additional tests than ordered in accordance with guidance in Medicare publication 100-02, Chapter 15, sections 80.6.2-4.

   In the 2018 MPFS final rule, CMS advises that in situations related to an updated or modified order by the furnishing professional, the AUC consultation information provided by the ordering professional with the original order should be reflected on the claim. CMS stated that this issue will be addressed in future rulemaking to develop policies relating to the identification of outlier ordering professionals.
   In this situation, the CPT code for the originally ordered service would not be reported on the claim as that is not the service that was performed. The AUC consultation could not be linked to the service originally ordered. The change from the ordered test to the test

recommended by the furnishing physician may not happen until the actual date of service of the procedure, long after the AUC information has been entered into the furnishing provider's EMR. In situations where there is more than one applicable imaging service furnished, it would be a burdensome, if not impossible, task to determine which furnished test corresponds to the AUC. Section 80.6.2-4 also allows the interpreting physician to order additional tests. It is unclear as to whether these additional tests require an AUC consultation and, if so, by whom.

2. Situations where a patient admitted as an inpatient is later determined to not meet criteria for inpatient admission and must be billed as either Inpatient Part B (UB04 bill type 121) or outpatient (UB04 bill type 131)

   Hospitals take great care to ensure that hospital patients are registered for the appropriate setting, i.e. inpatient vs. outpatient. Hospitals also take great care to ensure that claims are submitted for the appropriate setting. It is not uncommon for a hospital to determine, after the patient has been discharged, that the appropriate setting for billing purposes is Inpatient Part B or outpatient. In these situations the applicable imaging service would have been provided while the patient was in an inpatient status; however, for billing purposes the service must be submitted on a claim type that is processed under the OPPS payment methodology. Since the service was ordered and performed while the patient was an inpatient, there would be no AUC consultation. CMS must provide guidance on how providers are to handle this scenario.

**The PRT recommends that:**

1. **CMS should clarify that the proposal contained in the 2019 MPFS proposed rule would allow auxiliary personnel, as well as clinical personnel, to perform the AUC consultation under the direction of the ordering professional and incident to the ordering professional's services.**
2. **A methodology be established for situations where an AUC consultation was not performed and that these situations include 1) modification and/or addition of ordered test(s) in accordance with Medicare publication 100-02, Chapter 15, Sections 80.6.2-4 and 2) changes made to comply with the requirements for billing under the appropriate setting, i.e. inpatient vs. outpatient. This could be handled through the use of a modifier or included as a hardship exception or by allowing AUC consultation by the furnishing professionals after the service has been rendered.**

**Reporting AUC Consultation Information**

Section 1834(q)(4)(B) of the Social Security Act requires that payment for an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system may only be made if the claim includes certain information about the AUC consultation. In §414.94(k) CMS specified that only "furnishing professionals" must report AUC consultation information. Section 1834(q)(1)(F) of the Act specifies that a "furnishing professional" is a physician. CMS believes that section 1834(q)(4)(B) of the act clearly includes all claims paid under applicable payments systems without exclusion (PFS, OPPS, ASC). For this reason, CMS has proposed to revise §414.94(k) to clearly reflect the scope of claims and to clarify that reporting is not limited to the furnishing professional as defined in section 1834(q)(4)(B).

The PRT believes that requiring reporting of the AUC consultation information from both the provider that furnishes the technical component and the provider that furnishes the professional component is an unnecessary duplication of reporting and therefore doubles the administrative burden of the AUC program. It is unclear to the PRT what benefit this duplicate reporting will serve. Furthermore, the PRT believes that providers who submit claims on the 1500 claim form have the fields available to them to report the information required by PAMA; a furnishing professional, as defined in 1834(q)(1)(F) of the Act, would file claims using the 1500.

**The PRT recommends that**

1. **AUC consultation reporting be limited to avoid duplication of reporting and unnecessary burden to providers. This limitation should be according to the definition of furnishing professional as specified in 1834(q)(1)(F) of the Social Security Act as follows: FURNISHING PROFESSIONAL DEFINED.—In this subsection, the term `furnishing professional' means a physician (as defined in section 1861(r)) or a practitioner described in section 1842(b)(18)(C) who furnishes an applicable imaging service.**

**Claims-based Reporting**

An AUC consultation must be reported on claims submitted for payment. In the 2018 MPFS final rule, CMS agreed with many of the alternative methodologies suggested for reporting the required information. Many commenters reported that a unique consultation identifier (UCI) would be a less burdensome and the preferred approach. CMS has considered the UCI approach and determined it is not feasible to create the UCI taxonomy, determine a location for the UCI on claim forms, obtain the support and permission by national bodies to use claim fields and solve the underlying issue of the UCI being limited to claim level reporting. For this reason, CMS is proposing to use established coding methods, to include G-codes and modifiers, to report the required AUC information on Medicare claims.

Without further details regarding the specific methodology for reporting the applicable G-codes and modifiers, it is difficult for the PRT to understand how this methodology will result in more accurate reporting than the use of a UCI. Under the billing guidelines for the UB04, the PRT does not believe the use of G-codes and modifiers will solve the issue of claims level reporting versus the needed line item level of reporting any more efficiently than the use of a UCI would.
CMS speaks to the need to obtain the support and permission of national bodies to use claim fields to report AUC consultation information. The PRT believes the need for this support and approval would be significantly reduced if CMS limited the reporting requirement to just one of the national standard claim forms - the 1500. The PRT can think of only one circumstance where the service of the interpreting physician would not be reported on the 1500 claim form; the circumstance would be for critical access hospitals billing under Method II. If CMS were to limit the reporting requirement to the 1500 claim form, then the support and approval burden would be significantly reduced. The PRT also believes that the 1500 claim form currently allows for such reporting. For example, section 24 of the 1500 claim form allows for reporting of supplemental information for each line item.

**The PRT recommends that:**

1. **CMS provide more specific details on how the G-codes and modifiers will be used to meet the requirements of AUC consultation reporting for each service line submitted on the claim.**
2. **Absent timely provision of specific information related to the claim reporting requirements, the educational and operational testing period be continued through calendar year 2020.**
3. **The claim reporting requirement be limited to the 1500 claim form in order to facilitate implementation of the reporting requirement.**

**Significant Hardship Exception**

CMS allows for situations under which AUC consultation would not be required. In the proposed rule CMS has identified three criteria for a significant hardship exception. These criteria are:

> Insufficient internet access - Specific to the location where an advanced diagnostic imaging service is ordered
>
> EHR or CDSM vendor issues - Temporary technical problems such as installations or upgrades that impede access to the CDSM, vendors cease operations, or CMS de-qualifies a CDSM
>
> Extreme and uncontrollable circumstances - Disasters, natural or man-made, that have a significant negative impact on healthcare operations, area infrastructure or communication systems.

CMS is proposing that ordering professionals would self-attest if they are experiencing a significant hardship at the time of placing an order and that the attestation would be supported with documentation of significant hardship. Ordering professionals would communicate that information along with the AUC consultation information to the furnishing professional and it would be reflected on the furnishing professional's and furnishing facility's claim, by appending a HCPCS modifier. The modifier would indicate that the ordering professional has self-attested to experiencing a significant hardship and communicated this to the furnishing professional with the order.

The PRT appreciates the thoughtful consideration CMS has given to the difficulties that may be encountered by ordering professionals. While we support the concept of hardship exceptions, the process described in the proposed rule sets the expectation that the furnishing and interpreting professional would maintain documentation related to the hardship exception attestation. The PRT strongly disagrees that it is the responsibility of the furnishing or interpreting provider to maintain this documentation. The responsibility lies with the ordering professional who self-attests. The furnishing and interpreting professionals are playing the role of messenger by reporting information the ordering professional provides when ordering an applicable imaging service. To expect that the furnishing and interpreting professionals would receive and maintain documentation that is not pertinent to the clinical provision of the ordered service creates yet another administrative burden. In addition, this is an example of the erosion of the move to electronic health records. It is, and should be, the responsibility of the attesting physician to maintain the documentation to support his/her hardship exception.

The PRT believes that hardship exceptions should also be extended to the furnishing professional and/or facility. Vendor issues and/or extreme and uncontrollable circumstances could affect the

ability of those furnishing the test to report the AUC information. Furthermore, and as discussed above, situations where a patient classified as inpatient at the time a service is rendered and later billed as either Inpatient Part B or outpatient could qualify for a significant hardship exception.

**The PRT recommends that**

1. **CMS specify that documentation to support a hardship exception must be maintained by the ordering professional.**
2. **CMS recognize hardship exceptions that may impact the furnishing providers.**

***Regulatory Impact Analysis***

**Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

CMS reports that the Congressional Budget Office estimates that section 218 of PAMA would save approximately $200,000,000 in benefit dollars over ten years. Assuming that the savings would be the same for each year, the annual savings in benefit dollars would be $20,000,000. CMS also discusses other findings that could lead one to assume that there may be some savings when the regulations become effective beginning January 1, 2020. The AUC program, however, has different parameters and requirements than the other programs studied, so the results may not extrapolate to the Medicare population.

CMS provides estimates of the financial burden the AUC program is estimated to have on providers. For example, the impact of including AUC consultation information on the order to the furnishing professional or facility is estimated at $114,540,000[1] annually. The consultation burden, i.e. the cost to the ordering professional for consulting a CDSM, is estimated at an annual cost of $122,508,675[2]. These two annual cost estimates combined exceed the OMB estimate for ten years of savings, and they do not include all the annual costs that will be incurred. The PRT remains concerned that the cost for this program will outweigh the benefits.

**The PRT recommends, absent repeal of section 218 of PAMA:**

1. **That CMS consider implementing the AUC program on a smaller scale in order to assess and truly understand the benefit(s) of the program. Examples of the type of limitation that could apply include limiting the tests included in the requirement for AUC consultation, establishing a demonstration project, or implementing the requirement in a specific MAC region. This approach would allow for a controlled implementation where the cost and benefits as well as the challenges to both providers and CMS could be studied and supported with data.**

**Follow-up on Comments Submitted to the 2017 Proposed PFS Rule**

The PRT appreciates CMS' solicitation and consideration of comments regarding implementation of the AUC program. We recognize that CMS has received numerous comments, including those submitted by the PRT. Many of our comments have been addressed, and we acknowledge and appreciate that fact. Because we believe that the impact to provider operations will be significant, we have summarized those that were previously submitted, were

[1] FR Vol. 83, No. 145, July 27, 2018, 36053
[2] FR Vol. 83, No. 145, July 27,2018, 36050

not necessarily addressed, but are very important for CMS to consider from a provider's perspective as implementation of the AUC program continues. The PRT is available to provide any further provider feedback you may need as you move forward.

2017 Recommendations

- The PRT continues to recommend that CMS define the required information an ordering professional must include on every order to a furnishing provider related to the AUC consultation for applicable imaging services. In addition we continue to recommend that CMS provide education to ordering providers and tracking of those who do not adhere to the requirement.
- CMS should outline steps to be taken when an ordering professional does not provide AUC consultation information. This could include a modifier indicating that the ordering professional failed to provide the information, instructions as to whether an Advanced Beneficiary Notice should be provided to the patient, and a definition of reasonable efforts on the part of the furnishing provider to obtain the information from the ordering provider.
- The PRT recommends that a modifier be defined for use when an AUC consultation is not performed due to an Emergency Medical Condition or a suspected Emergency Medical Condition.
- 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 services were not medically necessary and reasonable.
- The PRT recommends that CMS prohibit post-payment reviews based upon AUC criteria not being met for a specific imaging service.
- CMS should consider transmission of the outcome from an AUC consultation directly to CMS from the CDSM, rather than a claim-based reporting requirement.

## Conclusion

The PRT appreciates the opportunity to provide comments on the CY 2019 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

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Provider Roundtable

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