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What is CMS Doing to Reduce Administrative Burden for Physicians?

Are you familiar with the CMS initiative, Patients over Paperwork, introduced in 2017? If not, you'll want to get up-to-speed. Many providers are watching the program's development with a close eye due to its intent to eliminate "overly burdensome and unnecessary regulations and sub-regulatory guidance in order to allow clinicians and providers to spend less time on paperwork and more time on their primary mission – improving their patients' health." Sounds like the relief providers have been waiting for.

In its second Request for Information (RFI) for this initiative in June, 2019, CMS solicited public comment and new ideas that weren't proposed during its first RFI. As of the Comments Close date of August 12, 2019, nearly 570 responses had been received.

Responses were encouraging, many hitting on common areas of clinician complaint directly related to challenges in the provision of timely patient care, billing and reimbursement, and participation in value-based payment programs such as the Merit-Based Incentive Payment System (MIPS).

Let's look at some of those comments and recommendations as they impact your radiology practice.

The **AMERICAN COLLEGE OF RADIOLOGY (ACR)**, which represents over 36,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, shared its belief that the Appropriate Use Criteria (AUC) program will directly contribute to the Patients over Paperwork initiative. The Program requires ordering providers to consult AUC when ordering advanced imaging studies including CT, MR, PET scans and nuclear medicine exams for Medicare patients beginning January 1, 2020. Beginning January 1, 2021, furnishing providers (the radiologists and facilities) will have to include the AUC consult information on their respective claims to Medicare to be paid for their services.

2020 is considered a testing year, during which payments will not be affected if claims are missing the AUC information. Beginning January 1, 2021, claims to Medicare for these advanced imaging services will not be paid if they don't contain the required information.

The ordering provider is required to consult, but doesn't have to adhere, to the AUC recommendations obtained from the consult. According to the ACR, this allows for the educational benefit of the AUC recommendations but doesn't create a "hard stop" in the ordering process like prior authorization (PA) programs are known to do.

The ACR maintains that PA programs are time-consuming, can overrule physician's decision-making and delay, or even deny, a patient from receiving a service. Referencing the results of the 2018 AMA Prior Authorization Physician Survey of 1,000 practicing physicians, the ACR points to multiple findings that support its contention that PA programs present "huge administrative burdens on physicians and, most importantly, have not been shown to reduce costs over time."

- 91% reported that PA delays patient's access to care
- 75% reported that PA can lead to patients abandoning their recommended course of treatment
- 28% reported that PA led to a serious adverse event



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- 65% reported having to wait at least 1 business day and 26% at least 3 days for a decision from the health plan
- 86% reported PA burdens to be extremely high
- 88% reported that PA burdens have increased over the last 5 years

This survey can be accessed at <https://www.ama-assn.org/system/files/2019-02/prior-auth-2018.pdf>.

Toward the goal of reducing administrative burden, the ACR recommends that CMS continue working with physicians and their professional societies to find resolution to the current complicated PA protocol.

In its response to the RFI, **RADNET**, a leading provider of freestanding, fixed-site diagnostic imaging services in the United States, voiced similar frustration with the current prior authorization landscape, proposing additional recommendations for improvement, such as:

Payers should create a central repository or clearinghouse featuring current PA policies, requirements and provider directories

- RadNet cites delays and costs associated with the ongoing challenge to find needed PA information for multiple payers and multiple insurance products, and proposes that a central repository to include current provider directories would streamline this part of the cumbersome process

Payers should provide clear and current guidance whether or not PA is required and, when required, be mandated to process authorizations within 24 hours for urgent requests and 48 hours for non-urgent requests

- RadNet maintains that inconsistent application of PA is “one of the greatest challenges in terms of patient scheduling and claims adjudication.” Describing how patients will often try to schedule a study without the necessary approved PA in place, RadNet explains that either the study will be postponed awaiting the approval, or the study will proceed and the radiologist incurs the risk of his/her claim denying and the subsequent resources to appeal for payment
- Additionally, RadNet proposes that payers should shoulder some of the burden in creating optimal processes that facilitate continuity of care. To that end, the organization recommends that payers and radiology benefits managers should be required to process authorizations within 24 hours for urgent health care services and within 48 hours for non-urgent services, starting from the original request

RadNet also addressed the topic of who is responsible for proving medical necessity for ordered diagnostic tests, stating that referral-based specialties, like radiology, should not have to verify the medical necessity of ordered procedures to receive payment for their claims.

The organization challenges the current common practice of radiologists being expected to provide documentation supporting medical necessity for a study as a condition for CMS (and other payers) to make payment for the interpretation. Not only does this delay payment and require additional administrative resources, but it “unfairly puts the onus on the radiology provider to do work that should have happened before the exam was ordered.” RadNet takes the position that radiology and other



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referral based specialties should be able to rely that the determination for medical necessity was made by the ordering practitioner based on his/her evaluation of the patient and corresponding factors.

RadNet contends that payers should direct requests for documentation to the ordering providers. If the radiologist's report is indeed necessary for payment, payers should have the capability to accept both the claim and the corresponding report through electronic means.

The **HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION (HBMA)** is a revenue cycle management authority with a membership representing nearly 350 revenue cycle management firms and professional billing entities. In its response to the RFI, the HBMA offered multiple recommendations for reducing administrative burdens that directly and continually bog-down the revenue cycles of physician practices. For example:

Local Coverage Determinations (LCD)

LCDs are coverage policies developed by the individual Medicare Administrative Contractors (MACs) and, as such, are inconsistent across MAC jurisdictions with regards to content and/or timing. The HBMA maintains that MACs "routinely fail to update their internal systems to properly accept and adjudicate their own LCDs" and since CMS updates its systems only quarterly, clinicians can wait months for the needed corrections and subsequent payments.

The HBMA recommends eliminating existing LCDs and ending the authority of MACs to develop new LCDs moving forward.

Provider Enrollment

The process of enrolling clinicians onto an insurance company's provider panel is frequently handled by a practice's billing or revenue cycle management organization. CMS uses the information obtained during this process to administer several programs and policies.

HBMA suggests a number of improvements that can be made to reduce the administrative burden and delay associated with the enrollment procedure overall:

- Allow practices to list their billing agent or revenue cycle management company on the enrollment form for documentation requests so those entities can directly receive and respond to the requests and eliminate the practice as a "middle-man"
- Expand PECOS to function as a centralized enrollment system for all payers, eliminating the delay associated with enrolling and maintaining the same information in multiple systems
- Allow medical records requests for providers to be sent electronically and stored in PECOS, reducing the manual process of mailing hard copies

Merit-based Incentive Payment System (MIPS) and Value-based Payment Programs

The HBMA describes MIPS and other value-based payment programs as continuing to place "significant administrative burden" on practices. The organization cites annual changes to these programs requiring resource-intensive monitoring and development



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and updating of ongoing workflow processes for reporting data as problematic and cumbersome to practices.

HBMA recommends that CMS simplify the reporting requirements for MIPS and other such programs to alleviate the pulling of resources from patient care.

The Patients over Paperwork initiative is gaining ground. APS will continue to follow progress and keep you apprised of key points along the way. We encourage you to review additional comments submitted to the RFI at the following link:

<https://www.federalregister.gov/documents/2019/06/11/2019-12215/request-for-information-reducing-administrative-burden-to-put-patients-over-paperwork>

Please contact Karen Harmon at APS with any questions: kmharmon@apsmedbill.com.