

September 7, 2018

The Honorable Kevin Brady  
Chairman  
Ways and Means Committee  
U.S. House of Representatives  
Washington, D.C. 20515

The Honorable Richard Neal  
Ranking Member  
Ways and Means Committee  
U.S. House of Representatives  
Washington, D.C. 20515

The Honorable Peter Roskam  
Chairman  
Subcommittee on Health  
Ways and Means Committee  
U.S. House of Representatives  
Washington, D.C. 20515

The Honorable Sander Levin  
Ranking Member  
Subcommittee on Health  
Ways and Means Committee  
U.S. House of Representatives  
Washington, D.C. 20515

Dear Chairman Brady, Chairman Roskam, Ranking Member Neal and Ranking Member Levin:

The undersigned organizations thank you for your commitment to cut red tape in the Medicare program to better serve patients. In this regard, we are united by the position that the Medicare Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging, if allowed to take effect, will become yet another duplicative and burdensome regulation.

The Protecting Access to Medicare Act of 2014 (PAMA) established the AUC reporting program. The number of clinicians affected by the program is vast, crossing almost every medical specialty, including primary care. The Centers for Medicare & Medicaid Services (CMS) describes the program as “massive.” CMS began implementation rulemaking in 2015. Even with the publication of the CY 2019 Medicare Physician Fee Schedule Final Rule later this year, the full compendium of regulations for the program will have yet to be written.

When Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 it consolidated the legacy physician quality reporting programs into what is now known as the Quality Payment Program (QPP). AUC consultation is inherent within the QPP’s dual tracks: the Merit-based Incentive Payment System (MIPS) and alternative payment models (APMs), both of which hold clinicians accountable for quality and patient outcomes, as well as for resource use. For instance, there are a number of existing measures for appropriate use of imaging in the Quality category of the QPP. In addition, CMS has added consultation of AUC as an Improvement Activity within MIPS — essentially folding key aspects of this program into MIPS.

While clinicians have embraced decision support and evidence-based AUC, requiring health care professionals to participate in a stand-alone AUC reporting program, in addition to the cost reduction and value-based activities of the QPP, will be burdensome, duplicative and costly, and due to a lack of appropriate measures, will not aid in determining whether patients are better served by the Program’s implementation. Because AUC reporting is congressionally mandated, any changes to the Program require legislative action. In the CY 2018 Medicare Physician Fee Schedule Final Rule, CMS clarified:

We are required by separate statutory authority provisions to implement the AUC program and the Quality Payment Program. Section 1834(q) of the Act requires AUC consultation information to be included on the furnishing professional's claim in order for that claim to be paid; we do not have discretion with respect to that requirement.

Rather than perpetuating these two separate programs, **health care professionals should be deemed compliant with the AUC Program if they meet the requirements of the QPP.** To accomplish this goal, our organizations seek modification to the law to afford clinicians maximum flexibility in the use of AUC in the least administratively burdensome manner possible while meeting the intent of PAMA to ensure appropriate imaging through enhanced education of ordering professionals and support for clinicians in achieving high-value performance in MIPS or APMs.

The following aspects of the AUC reporting program, as set forth in statute, underscore its breadth, cost and burden:

- Every health care professional who orders an advanced diagnostic imaging test will be required to consult AUC using a clinical decision support mechanism (CDSM) that has been qualified by CMS.
- Every health care professional who furnishes an advanced diagnostic imaging test will be required to report that the ordering health professional consulted AUC.
- The AUC Program sets up a complex exchange of communication between the ordering professional and the furnishing professional regarding the AUC consultation.
- CMS is proposing that furnishing professionals would use established coding methods — G-codes and modifiers — to report the required AUC information on Medicare claims. This approach has already been rejected by the National Uniform Claims Committee (NUCC) and National Uniform Billing Committee (NUBC), which concluded that using G-codes would be burdensome but that all options to report AUC data will be burdensome and costly for ordering and furnishing professionals.
- Nearly 60 percent of respondents to a study conducted by the Association for Medical Imaging Management estimate it will cost \$75,000 or more for a practice to implement a CDSM. Physician practices and hospitals will also incur additional costs to update their billing systems to transmit necessary AUC data to CMS. CMS estimates 579,687 ordering professionals will be subject to this program; yet, CMS admits that information on the benefits of physicians adopting qualified CDSMs or automating billing practices for specifically meeting the AUC requirements in this proposed rule does not yet exist, and information on benefits of the program overall is limited.
- The CDSM tools are not all embedded in electronic health record (EHR) systems, thereby requiring ordering professionals to use an additional software program outside of their

regular EHR. Furthermore, free tools for physicians who cannot afford CDSM tools, especially those in small and rural practices, simply transfers the cost of CDSM acquisition to increased administrative burden.

We appreciate the way in which you have engaged the health care community in a dialogue about ways to cut regulatory red tape. Our organizations ask for your support and action this year to relieve clinicians of the much-anticipated regulatory burden of the AUC reporting program. To this end, we look forward to working with you and the committee toward a solution.

Sincerely,

Alliance of Specialty Medicine  
American Academy of Family Physicians  
American Academy of Neurology  
American Academy of Orthopaedic Surgeons  
American Academy of Otolaryngology-Head and Neck Surgery  
American Academy of Physical Medicine and Rehabilitation  
American Association of Neurological Surgeons  
American College of Cardiology  
American College of Obstetricians and Gynecologists  
American College of Osteopathic Surgeons  
American College of Physicians  
American College of Surgeons  
American Gastroenterological Association  
American Medical Association  
American Osteopathic Association  
American Society for Dermatologic Surgery Association  
American Society for Gastrointestinal Endoscopy  
American Society for Surgery of the Hand  
American Society of Nuclear Cardiology  
American Society of Plastic Surgeons  
American Urological Association  
Association of Black Cardiologists  
Cardiovascular Advocacy Alliance  
Congress of Neurological Surgeons  
Heart Rhythm Society  
Medical Group Management Association  
National Association of Spine Specialists  
Society for Cardiovascular Angiography and Interventions