

The following is a summary of the public comments received on the proposed collection of information under the Appropriate Use Criteria (AUC) for Diagnostic Imaging Services program for AUC consultations:

Comment: Some commenters strongly supported the proposal to begin the AUC consultation and reporting requirement in January 2019 and further stated that additional delays beyond 2019 are not warranted. They asserted that physicians need certainty that the AUC program will move forward on a predictable timeline and will not be subject to continued changes. Some commenters stated that they are prepared for this program to begin and that others will be prepared within one year. In contrast, other commenters do not want this AUC program implemented in 2019 or at any point in the future. These commenters wanted the program to be delayed indefinitely, discontinued or modified to the extent that participation be only voluntary as opposed to mandatory.

Response: We recognize the interest from commenters in better understanding our separate and distinct efforts to improve quality, and note that the AUC program promotes AUC to ensure the patient gets the right test at the right time and reduces inappropriate imaging. We are required by separate statutory provisions to implement the AUC program and 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. In response to public comments we are further delaying the effective date for the AUC consultation and reporting requirements for this program from January 1, 2019 as proposed to January 1, 2020. We are also finalizing a voluntary period during which early adopters can begin reporting limited consultation information on Medicare claims from July 2018 through December

2019. During the voluntary period there is no requirement for ordering professionals to consult AUC or furnishing professionals to report information related to the consultation.

Comment: Commenters acknowledged that the annual burden estimated for the program appears to outweigh the Congressional Budget Office estimated savings. A few commenters stated we should also compensate physicians for consulting AUC and recommended an imaging service volume-weighted average as an alternative to estimates based on the hourly rate of a family and general practitioner. Another commenter requested the estimate use a volume weighted average that includes specific specialties that are paid at a higher rate than family and general practitioner since they are paid at a lower rate. A few commenters stated the estimated 2 minutes was inaccurate, and instead proposed an additional 3-5 minutes to consult AUC. One commenter noted that such estimates were based on the Medicare Imaging Demonstration report to Congress (Timbie et al., Medicare Imaging Demonstration Final Evaluation: Report to Congress. Rand Health Q. 2015 Jul 15;5(1):4.). Other commenters disagreed and stated that impact on the workflow of ordering professionals would be minimal, and acknowledged that current processes are doing a poor job of reducing inappropriate utilization to protect Medicare beneficiaries.

Response: As discussed earlier in this section, we conducted an initial analysis of recalculations based on volume weighted averages specific to different specialties again using the BLS May 2016 National Occupational Employment and Wage Estimates, which included both higher paid physicians as suggested by the commenter and lower paid non-physician practitioners because advanced diagnostic imaging services are ordered by a variety of medical professionals and our claims data analysis supports such inclusion. The resulting estimates for both the collection of information and regulatory impact analysis were slightly lower than our original estimates using the mean hourly wage for family and general practitioner, so we did not

adjust the estimates using specialty specific information. However, as the AUC program evolves we will continue to assess the burden and reevaluate the estimates, and we will update this PRA package as necessary going forward.

Comment: Some commenters recommended that we revisit the estimates to include the communication between ordering professional to the furnishing professional, as well as the reporting of AUC consultation information by the furnishing professional. Commenters stated that the proposed estimate does not include any time for the work the furnishing professional would perform to: (1) validate information sent from the ordering professional; (2) recognize ordering professionals with a significant hardship exception; (3) training; and (4) add new or additional health IT interoperability between EHR systems. One commenter requested that additional consideration be made for costs to purchase or subscribe to specific proprietary CDSM products, and costs to build or incorporate software interfaces.

Response: We appreciate these commenters' views and agree that furnishing professionals will incur burden attributed to the AUC program. However, we do not foresee such burden being incurred during the voluntary reporting period. We note that during the voluntary reporting period that begins July 2018, furnishing professionals are not expected to change how they currently interact and communicate with ordering professionals and any information related to an AUC consultation will be communicated using existing methods. We also point out that in the CY 2019 PFS rule we will revisit the significant hardship exception to continue working toward alignment with MIPS. While we do not expect ordering professionals in need of a significant hardship exception to participate in the voluntary period, a significant hardship exception process will not be operationalized in time for the 2018 voluntary reporting period, therefore furnishing professionals will not have the ability to identify ordering

professionals with the exception as none will have been granted yet. Generally, we expect very few changes to be made in the early part of the voluntary period, particularly in CY 2018.

Rather, the voluntary period is most likely to be used by ordering professionals that are already consulting AUC using a qualified CDSM and be reported by furnishing professionals that are already within the same EHR system as the ordering professionals. With respect to costs incurred for IT, the AUC program has a qualified CDSM available free of charge and the statute does not provide for additional compensation to affected professionals to ensure compliance with program requirements. We will update estimates as necessary to reflect changes to this program as it moves from voluntary participation to required participation at which time we expect to see changes in behavior to comply with reporting requirements.