NYSRS Economics Committee **5 January 2024**

ACR Releases Preliminary Radiology-Specific Summary of Medicare Physician Fee Schedule Final Rule

The CMS released its 2024 Medicare Physician Fee Schedule (MPFS) Final Rule Nov. 2. The ACR has prepared a radiology-specific preliminary summary of the rule, which indicates 32.74 PFS conversion factor in 2024, a $1.14 decrease from the 2023 conversion factor of $33.89, or a decrease of approximately 3.4%.

The College continues to review the proposed rule and will provide a detailed summary in the coming days. If you have questions, contact Angela Kim, ACR Senior Director, Economics and Health Policy.

ACR Releases Preliminary Summary of HOPPS Final Rule

The CMS released its 2024 Hospital Outpatient Prospective Payment System (HOPPS) Final Rule Nov. 2. The ACR prepared a radiology-specific preliminary summary of the final rule, which increases the conversion factor from 2023 by 3.1% to $87.382 for 2024.

The agency also created a 2024 HOPPS final rule fact sheet .

The College continues to review this final rule and will provide a detailed summary in the coming days. If you have questions, contact Kimberly Greck, ACR Senior Economic Policy Analyst.

Will Congress Address Medicare Physician Payment Cuts?

The CMS finalized a 3.37% cut in Medicare physician payment in the Calendar Year 2024 Medicare Physician Fee Schedule (MPFS) final rule in November, which led to increased pressure by the ACR and the physician community at large for Congress to stop the full cut.

The College led a coalition of physician and non-physician groups in a communication to congressional leadership, urging Congress to stop the full cut, which is the result of efforts to increase payments for primary care. In addition, ACR members have also been contacting their lawmakers through a call-to-action which urges lawmakers to address the cut.

Despite a year-long effort by the ACR and the house of organized medicine, Congress has not addressed looming Medicare conversion factor cuts before the end of 2023. As such, the CMS-finalized -3.37% conversion factor reduction will have gone into effect beginning Jan. 1, 2024. The ACR will continue to

work with the entire provider community to pressure Congress to mitigate these planned cuts and expect the House and Senate will address this issue when the Congress debates the next government-wide funding Continuing Resolution that expires on Jan. 19, 2024. The ACR anticipates that once Congress finally votes on this payment issue, claims will be adjusted retroactive to Jan. 1, 2024.

Although there is no congressional consensus yet, ACR is encouraged by the various proposals to address these cuts. On Nov. 8, the Senate Committee on Finance voted in favor of the Better Mental Health Care, Lower-Cost Drugs, and Extenders Act, which included a 1.25% increase to the 2024 Medicare physician payment conversion factor. More recently, the House Energy and Commerce Committee voted in favor of a similar proposal, H.R. 6545, the Physician Fee Schedule Update and Improvements Act, that also includes a 1.25% increase to the conversion factor. Lastly, a bipartisan group of legislators, led by Rep. Greg Murphy, MD (R-NC), introduced H.R. 6683, the Preserving Seniors' Access to Physicians Act—legislation, that if enacted, would completely eliminate the scheduled 3.37% physician payment cut. It's possible that one of these proposals will be voted on and finalized in January.

The ACR asks to stay tuned to updates on this highly fluid Congressional situation. For more information, contact Rebecca Spangler, ACR Senior Government Affairs Director.

Feds Appear to Acknowledge Radiology Surprise Billing Implementation Concerns in New Proposed Rules

The U.S. Departments of the Treasury, Labor, and Health and Human Services issued a new proposed rule Oct. 27, that outlines policies related to the No Surprises Act (NSA) independent dispute resolution (IDR) process. The rule addresses disclosure of claim eligibility information by insurers, communication during the open negotiation period, collection of administrative fees and batching multiple claims into a single IDR dispute.

On initial review of the proposed rule, the departments appear to address the concerns raised by the ACR with regard to lack of communication about claim eligibility, IDR backlogs and access to the IDR process for low-cost claims, including batching requirements. The government proposes to expand batching to allow multiple codes from a single patient encounter. In addition, the departments propose to allow batching by groupings of CPT codes, rather than single CPT codes. These are positive changes, but ACR remains concerned about other proposals, including limiting batching to 25-line items in a single dispute.

The Republican members serving on the U.S. House Committee on Ways and Means sternly demanded in a Nov. 9 letter that the Biden administration follow lawmakers' clear intent in implementing the No Surprises Act, legislation passed in 2020 to protect patients from surprise medical bills.

ACR continues to review the details of this proposed rule and will provide a detailed summary. For more information or if you have questions, contact Katie Keysor, ACR Senior Director of Economic Policy.

Federal Government Resumes Independent Dispute Resolution for Batched Claims

The CMS announced Dec. 15 that the portal for providers and insurers to file payment disagreements related to the No Surprises Act is again open for the initiation of new batched claim disputes. CMS temporarily suspended the independent dispute resolution (IDR) process Aug. 3, following the U.S. District Court for the Eastern District of Texas' decision in the lawsuit known as Texas Medical Association (TMA) IV; that decision vacated regulations related to batching provisions and the administrative fee that must be paid to file a disputed claim. The portal was reopened for single claims Oct. 6.

The American College of Radiology strongly opposed the extended pause of the IDR process for batched claims, as many imaging claims eligible for dispute are less than the current $50 administrative fee required to be paid to initiate the process. While the College is pleased that the federal IDR portal is now completely reopened, there are significant concerns with the 20 business-day extension allowed for claims where the initiation deadline fell on any date between Aug. 3, 2023, and Dec.15, 2023. Parties only have until Jan. 16, 2024, to initiate batched disputes that have been on hold since August.

When the federal IDR portal reopened for single claim disputes in October, a 20 business-day extension was provided and was not enough time for stakeholders to submit disputes for claims that were on hold for more than two months. Batched claim disputes were on hold for twice as long and are being held to the same 20 business-day extension, occurring during the winter holiday season. The ACR is working with the American College of Emergency Physicians and the American Society of Anesthesiologists to communicate with CMS that additional time is needed.

For more information or if you have questions, contact Katie Keysor, ACR Senior Director of Economic Policy.

CMS Finalizes Pause to Imaging Appropriate Use Criteria Program

The Centers for Medicare and Medicaid Services in the 2024 Medicare Physician Fee Schedule final rule finalized its proposal to pause the implementation of the Protecting Access to Medicare Act (PAMA) imaging appropriate use criteria (AUC) program. CMS continues to have concerns with the real-time claims processing aspect of the act. The final rule emphasizes the agency's support of the PAMA AUC program, but says more time is needed to reevaluate the program to ensure that imaging claims are not inappropriately denied.

The PAMA imaging AUC program, passed by Congress and signed into law in 2014, requires ordering providers to consult AUC developed by provider-led entities through a clinical decision support mechanism when ordering advanced diagnostic imaging, including CT, MR, PET and nuclear medicine, for Medicare Part B patients. It was designed as an alternative to prior authorization to decrease inappropriate imaging. If the program were to be fully implemented as currently written in law, payment for imaging services that do not contain the appropriate AUC consultation information on applicable claims would be denied. The program has been operating in an "educational and operations testing period" without payment penalties in place since Jan. 1, 2020. The decision to pause the program includes pausing the ongoing educational and operations testing period, effective January 1, 2024.

Despite the implementation barriers necessitating the reevaluation of the program, CMS recognizes the value of AUC to improve utilization patterns for Medicare beneficiaries. The rule states, "We want to acknowledge and emphasize the value of clinical decision support to bolster efforts to improve the quality, safety, efficiency and effectiveness of health care. We welcome and encourage the continued voluntary use of AUC and/or clinical decision support tools in a style and manner that most effectively and efficiently fits the needs and workflow of the clinician user. Across many specialties and services, not just advanced diagnostic imaging, clinical decision support predates the enactment of the PAMA and, given its utility when accessed and used appropriately, we expect it to continue being used to streamline and enhance decision making in clinical practice and improve quality of care."

CMS states multiple times within the final rule that they will "continue efforts to identify a workable implementation approach and will propose to adopt any such approach through subsequent rulemaking, including implementing any amendments Congress might make." Providers are urged to continue use of Clinical Decision Support tools.

For more information, contact Katie Keysor, ACR Senior Director, Economic Policy.

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