Dear Chris:

We thank you, Kathy Bryant, Craig Dobyski, and Felicia Rowe for meeting with us on September 4th to discuss the date of service of the professional component (DOS-PC) of imaging services and the subsequent need for the Centers for Medicare & Medicaid Services (CMS) to issue national guidance on this issue. We appreciate the opportunity to present this topic and the thoughtful engagement by all participants.

Date of Service

We would again reiterate the DOS-PC of imaging services has been, and should continue to be, the date the exam’s technical component (TC) was performed (i.e. the date the patient was imaged). We recommend CMS promulgate national guidance consistent with this position to eliminate the potential for Medicare Administrative Contractors (MACs) to issue conflicting local policy throughout the Medicare program. Our recommendation is based on the following:

- **Administrative**

  Radiology practices utilize a multitude of clinical and billing software technologies in managing a high volume of imaging services and the processing of claims. Industry practice standards have dictated such systems define the DOS-PC as the date the technical component (DOS-TC) of the exam was performed.

  Modifying clinical and billing systems is time-consuming and costly, in general, and the changes to accommodate a different DOS-PC and DOS-TC are not insignificant. For hospital-based radiologists, such changes are made even more difficult because decisions on technology (e.g., purchase, maintenance, upgrades, modifications) are made by the hospital and, thus, outside of the radiologist’s control. The DOS originates and directly tracks from hospital information systems/electronic medical records (EMRs) as well as picture archiving and communication systems (PACS).

  More importantly, the DOS-TC definition avoids unintended confusion among the ordering physicians, treating physicians and other medical providers regarding exactly when prior examinations were performed. This is because patient medical records in the hospital setting (POS 21, 22, 23) are all filed based on the DOS-TC. A split reporting process that separates DOS-TC from DOS-PC will cause significant confusion among providers, be detrimental to acute and emergent patient care, and increase the potential for treatment errors, especially when multiple exams have been performed on the same day.
**Beneficiary**

Medicare beneficiaries will be confused about why there are different dates of service in their Explanation of Medicare Benefits (EOMB). (The common response is: “I did not have anything on that day.”) Many patients are already confused over why they have received two bills (one for the PC and another for the TC). Two dates of service will exacerbate this problem, and likely cause unnecessary reports of fraud and abuse or at a minimum, cause patients to contact providers and/or MACs to communicate their confusion and unwarranted suspicions.

**“Cusp”/“Crossover” Situations**

Beyond the “general” confusion multiple dates presents for the single patient encounter, there are two distinct situations that create undue burdens for Medicare and Medicaid patients: (1) calendar “cusp” and (2) “crossover” claims.

Changes in insurance plan coverage typically coincide with the first of any given month. A calendar “cusp” situation arises when a patient changes insurance plans. For example, a patient with commercial insurance has a technical imaging service performed on or near the last day of a given month and the study is interpreted on a day in the subsequent month (e.g., the study is performed at 11:00pm on September 30th, but interpreted at 12:30am on October 1st) once the patient has changed to Medicare. These “cusp” issues create significant patient confusion when trying to understand the multiple explanation of benefits from different payers and may occur even more frequently as patients enter and exit Medicaid programs.

The second “crossover” issue is when Medicare is primary and commercial insurance is secondary, or vice versa. The commercial insurance industry recognizes the PC and the TC services are essentially one “event” and links the dates of service to the date the patient was imaged. If Medicare requires “de-linkage” of these two services, then crossover of claims after the primary payer’s adjudication will require intervention, creating additional work for all parties as these claims are denied, appealed, then eventually approved and paid anyway.

**Commercial Insurers**

Commercial (non-Medicare) insurers link technical and professional dates of service for coverage determinations, pre-certifications, reconciliation, and auditing. While commercial insurers often follow Medicare’s lead with respect to payment policy, it is unlikely they would adopt a DOS definition other than that of the technical component primarily due to the significant costs of re-programming their systems. Pre-certification of imaging procedures by commercial insurers or radiology benefit managers (RBMs) is driven by the technical component, i.e. the professional component is not pre-certified as a separate, standalone service. If the DOS-PC is different from the DOS-TC, the professional component claim will be denied for lack of pre-certification. Consequently, radiology practices may find themselves in the burdensome situation of having to manage two processes (Medicare vs. commercial) to accommodate different DOS definitions.

**Clinical**

The interpretation of images acquired on a specific date (DOS-TC) provides information on the patient as of the date of the exam. Therefore, the DOS-PC should be reflected as the DOS-TC to eliminate any confusion regarding the patient condition at a given point
in time. For example, if the DOS-PC was reported later than the DOS-TC, a treating physician may mistakenly believe the patient’s clinical parameters occurred on the later DOS-PC, rather than the more accurate and chronologically earlier DOS-TC. In fact, following the very sequence of clinical events captured through follow-up studies could be jeopardized. This could have disastrous consequences when the order of prior surgeries, support tube/line management and medical treatments impact clinical decision making.

Defining DOS-PC as the date the interpretation was rendered lacks clarity. There are many methods of consulting with the treating physician that occur throughout the interpretation process including the availability of dictated reports pending transcription, communication of critical results via PACS, electronic tasks in the EMR, telephone consults and face to face communication, all while waiting for the final report to be issued.

Certain radiology exams may span multiple days (e.g., nuclear medicine, small bowel series) and differing DOSs will likely cause confusion with the medical staff and possibly impact patient care. A consistent DOS is important for determining when to order/perform follow-up studies.

**Standard of Care**

Defining DOS as the date the exam was performed is the current standard of care because of the administrative and clinical reasons provided herein. This standard of care is evidenced in a February 2013 RBMA informal survey which showed nearly 89 percent of PC billers use the date of the technical service for the DOS-PC.

**Medicare Fraud and Abuse**

We appreciate CMS’ role as the prudent steward of the Medicare program in being ever vigilant against fraud and abuse. We also understand CMS’ responsibility and accountability to Congress, the Office of the Inspector General (OIG), and other branches of the federal government. When it comes to Medicare, the vast majority of physicians “play by the rules” and are not seeking to “game the system.”

The PC and TC of an imaging exam are inextricably linked; only in very rare instances does the PC exist without the TC (e.g. a second opinion on outside films). If the PC is a standalone service, the implication for fraud cannot be ignored since there is no link to a corresponding TC. We believe linking the DOS-PC to the TC helps prevent fraud and abuse because DOS is determined by the facility (e.g., hospital, imaging center) and is outside of the interpreting physician’s control.

- **Multiple Procedure Payment Reduction (MPPR)**

  The MPPR applies to the professional component when multiple advanced imaging studies are interpreted during the same session by the same or different physicians in the same group practice. While the DOS-TC is fixed by the facility, the interpretation date can be more variable depending on such factors as workload, access to prior studies, the time of day (e.g., near midnight) the imaging study was performed, etc. Hypothetically, a physician looking to game the system could interpret MPPR-eligible exams on separate days to circumvent the MPPR. By linking the PC service to the DOS-TC, it seems that CMS could more objectively identify services where the MPPR for the PC would likely apply.
An imaging study represents a continuum of care which starts at registration and ends with the issuance of the final signed interpretative report. When the DOS-PC matches the DOS-TC, an auditor can follow the progression of care from start to end and readily determine if the study in question was: (1) actually performed (i.e. the TC) and (2) interpreted (i.e. the PC). In the alternative, if the DOS-PC is independent from the TC, the auditor could determine the interpretation was rendered, but then would have to figure out when the exam was performed.

**Wisconsin Physician Services (WPS) Position on DOS**

Understandably, we are disappointed by CMS’ conclusion that WPS is acting within its authority when establishing the DOS as the date the interpretation is rendered. We continue to maintain this position is inappropriate and implore CMS to rethink and retract its position that WPS has the discretion to make the DOS determination unilaterally pending a national decision.

We acknowledge and support local MAC discretion in certain areas, particularly as they relate to local/regional clinical practice variation. WPS’ decision has far-reaching implications beyond conflicting with longstanding practice of the DOS being the date of the TC. Specifically it: (1) creates a significant compliance risk, (2) complicates cross-MAC billing, and (3) extends beyond radiology, affecting non-imaging PC/TC services.

**Compliance Risk**

By its action, WPS has placed thousands of radiologists and non-radiologists in an untenable and unacceptable position – a position to which physicians practicing in other regions are not exposed. In a technical, but very real sense, WPS has made thousands of physicians non-compliant because they have strayed from using a convention that is as old as diagnostic testing itself - the convention that date of service for both the TC and PC is the date the patient had the exam. Putting well-meaning physicians in this position simply should not happen.

**Cross-MAC Billing**

Medicare’s claims processing manual stipulates claims should be sent to the MAC in which the service was provided. It is unclear whether: (1) non-WPS providers submitting claims to WPS are required to comply with WPS’ policy and (2) if WPS providers submitting claims to MACs other than WPS are required to comply with WPS’ position. Finally, what happens when a state leaves WPS’ jurisdiction as in the case of Illinois effective on October 1, 2013?

**WPS’ Position Goes Beyond Radiology**

WPS recently confirmed their DOS policy extends to the professional component of all diagnostic tests, including pathology1. While radiology is just appreciating the implications of WPS’ decision, we believe few within pathology are aware of this ruling and its implications. We understand the common convention in pathology is to report DOS based on when the specimen was obtained which is comparable in concept to when

---

1 Email communication from WPS to Michael Bohl (WPS Iowa Administrative CAC Member and September 4, 2013 meeting participant). Available upon request.
the exam is performed in imaging (TC). As the WPS position becomes more widely known, this will have significant impact on other specialties such as cardiology, neurology, orthopedics, and others.

**Multi-State Enrollment**

We are encouraged by the prospect of working with CMS to streamline physician enrollment across multiple states or Medicare Administrative Contractors (MACs). Lessening the number of duplicate enrollments and redundant credentialing caused by state or jurisdictional boundaries will ease the administrative burden on physician practices and MACs alike. During our meeting we provided an example of redundant processes within a single MAC but our concerns also include redundant enrollment and credentialing across MACs. We will follow-up with CMS’ Provider Enrollment Group (PEG) to continue this dialogue.

****

In conclusion, we appreciate the opportunity to discuss important issues affecting the practice of radiology with CMS. Through meetings such as this, we hope to advance a better understanding of each other’s concerns and explore areas of collaboration.

Please contact Michael Mabry, RBMA’s Executive Director, at 703.621.3363 or mike.mabry@rbma.org if you have any questions or want additional information.

Sincerely,

American College of Radiology (ACR)
Healthcare Billing & Management Association (HBMA)
Medical Group Management Association (MGMA)
Radiology Business Management Association (RBMA)

cc: Marc Hartstein, CMS
    Kathy Bryant, CMS
    Craig Dobyski, CMS
    Felicia Rowe, CMS
    Zabeen Chong, CMS