ASHA
American
Speech-Language-Hearing
Association

Submitted via email: ProgramIntegrityRFI@cms.hhs.gov

November 19, 2019

Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Request for Information on Using Advanced Technology in Program Integrity

Dear Administrator Verma:

On behalf of the American Speech-Language-Hearing Association, I write to offer comments on the Request for Information on Using Advanced Technology in Program Integrity.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 204,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students.

Our comments focus on ensuring the use of artificial intelligence and prior authorization in program integrity efforts meet the common goals of payers, clinicians, and patients to protect the system from improper payments while maintaining access to care for Medicare beneficiaries and minimizing clinician burden.

Questions Pertaining to AI Medical Record Review Tools

1. **Do AI medical record review tools exist that can read a medical record and determine whether it is in compliance with a set of coverage guidelines for a given item/service?**

   ASHA appreciates CMS's efforts to be forward-thinking and learn from other sectors of the health insurance marketplace in order to protect the Medicare trust fund and ensure Medicare beneficiaries have access to the services they need. However, ASHA recommends that CMS proceed with caution regarding the use of artificial intelligence (AI) as a fraud prevention tool. AI tools are in their infancy with limited implementation. If poorly structured, these tools could lead to inappropriate denials, which are burdensome and costly to clinicians. Therefore, while AI can be a helpful adjunct to more traditional forms of fraud, waste, and abuse prevention techniques (e.g., claims processing edits, manual review of medical records), it cannot replace such efforts.

   Keyword searches of the medical record documentation to ensure the documentation supports the diagnosis and procedural coding submitted via claims

constitute a currently applied example of AI. For example, if a provider submits a claim with diagnosis and procedural codes associated with a swallowing impairment and the medical record documentation did not include key terms associated with swallowing impairments, such a result could trigger a more comprehensive medical record review by a clinician.

2. If AI tools were available that could review records in advance of filing Medicare claims, which we refer to as medical record self-checking services, would providers and suppliers use these tools?

Widespread adoption of AI tools by stakeholders, including clinicians and payers, will depend on their utility, accessibility, and affordability. Clinicians will not be able to use them effectively without payers making their coverage policies publicly available and easy to understand. Clinician utilization of AI tools depend on how much it costs, if it can be integrated into electronic health records (EHRs), and if its available both online and offline. AI tools should not only be available via EHRs. AI integration into EHRs might increase the cost of these products making them out of reach for some clinicians. Whenever possible 'self-checking' AI tools should be free or low-cost to enable greater access for clinicians.

Clinicians could use AI to help ensure medical record documentation compliance with payer requirements in advance of submitting a claim. This can avoid costly audits and post-payment claim denials. Clinicians require transparency that payers would not use self-checking AI against them in an audit. Also, payers could incentivize the use of AI for compliance with payer requirements. For example, if clinicians attest to the use of AI, the payer should exempt them from audits for a period of time (e.g., one year).

Questions for Health Care Providers and Suppliers

22. For which items/services would it be most helpful to you and your patients to have a provisional Medicare coverage decision before the item is delivered or service is rendered?

ASHA appreciates CMS's interest in establishing prior authorization for certain items or services. However, prior authorization is best used to identify high volume, low dollar services. One significant problem with application of prior authorization is that effectiveness relies on the appropriate resources to process the prior authorizations in a reasonable timeframe. For example, in 2006 and 2012, CMS used prior authorization to pay for speech-language pathology services over the medical review threshold of $3,700. In both instances, Medicare contractors did not process prior authorization requests in a timely fashion, sometimes taking in excess of 30 days to provide initial determinations to clinicians. This resulted in either delayed patient care or claim denials after the clinician had provided hours of treatment they saw as medically necessary. Such denials left clinicians without recourse for their lost reimbursement even though the statute required a specific response window that CMS never enforced on its contractors.

In addition, the foundational principles of prior authorization must include immediate or automatic exemptions for select conditions or circumstances that place a patient's health and/or life in serious jeopardy. Payers must establish and enforce clear prior authorization timelines for initial determinations and appeals. Clinician burden is significantly reduced when the documentation requirements for prior authorization requests are transparent through publicly available and clearly stated documentation requirements.

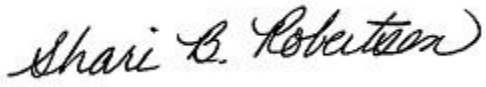
Questions on Provider Enrollment

32. CMS affiliation and ownership information is presently self-reported today. What data sources are available for CMS to collect and potentially enhance the Advanced Provider Screening System (APS), so that CMS can examine and validate affiliation information and/or ownership data?

CMS should review the Council for Affordable Quality Healthcare's enrollment process used by private insurers. It is a single credentialing process a clinician can use to enroll in multiple health plans instead of completing multiple applications. This format might be a helpful model to CMS as it seeks to enhance its enrollment processes.

Thank you for considering ASHA's comments for this request for information. If you or your staff have questions, please contact Sarah Warren, MA, ASHA's director for health care policy, Medicare at swarren@asha.org.

Sincerely,



Shari B. Robertson, PhD, CCC-SLP
2019 ASHA President