



January 28, 2019

The Honorable Donald Rucker, MD  
National Coordinator  
Office of the National Coordinator for  
Health Information Technology  
Mail Stop: 7033A  
Mary E. Switzer Building  
330 C Street, S.W.  
Washington, DC 20201

***RE: Draft Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs.***

Dear Dr. Rucker:

RadNet appreciates the opportunity to comment on Office of the National Coordinator for Health Information Technology's (ONC) draft *Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs*.

RadNet, Inc. is the leading national provider of freestanding, fixed-site diagnostic imaging services in the United States based on the number of locations and annual imaging revenue. Our goal is to deliver high-quality, conveniently accessible care in the most cost-effective manner possible -- all of which makes us the alternative to the higher-priced hospital and health system-based or owned imaging provider. RadNet has a network of 341 owned and/or operated outpatient imaging centers. RadNet's markets include California, Maryland, Florida, Delaware, New Jersey, and New York. Our 341 imaging centers, more than 750 radiologists, and approximately 7,100 employees perform an estimated seven million procedures annually. In addition, RadNet provides radiology information technology solutions, teleradiology professional services, and other related products and services to customers in the diagnostic imaging industry.

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The report is in response to HHS' the statutory requirements under §4001 of the Cures Act which requires a plan of action be articulated to reduce regulatory and administrative burden relating to the use of health IT and EHRs. Specifically, the Cures Act directs HHS to: (1) establish a goal for burden reduction relating to the use of EHRs, (2) develop a strategy for meeting that goal, and (3) develop recommendations to meet the goal. The report outlines three primary goals informed by extensive

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stakeholder outreach and engagement for reducing health care provider burden: (1) reduce the effort and time required to record information in EHRs for health care providers during care delivery, (2) reduce the effort and time required to meet regulatory reporting requirements for clinicians, hospitals, and health care organizations, and (3) improve the functionality and intuitiveness (ease of use) of EHRs. Consistent with these goals and based on findings and feedback from stakeholders and workgroups, the report presents strategies and recommendations concerning: (1) clinical documentation, (2) health IT usability and the user experience, (3) EHR reporting, and (4) public health reporting. Our comments are directed towards these strategies and recommendations.

### Clinical Documentation Strategies and Recommendations

#### **“Note Bloat” in the Radiology Report**

The report recognizes correctly that health care providers must complete a range of documentation tasks to satisfy administrative and billing-specific requirements. Furthermore, these tasks are often labor and time intensive, imposing significant burdens on health care providers. Clinical notes and other information are entered repeatedly throughout the EHR. The report concludes that EHRs and other health IT (HIT) systems have the potential to streamline documentation and reduce the time and effort required to meet regulatory reporting requirements for physicians, practice managers, and administrators to document in a manner that supports these necessary functions of the medical record. EHR systems should minimize redundancy in data entry. For instance, an auto-fill feature should populate same fields throughout the record. Relevant information from other systems should be brought into the current record and not be replicated.

While the report focuses on evaluation and management (E/M) services, radiology exhibits the same challenges, burdens, and potential for EHR/HIT-based solutions. The radiology report is the written communication between the radiologist who interpreted the imaging study and the physician who requested the examination and serves as the formal documentation and communication of the results of that examination. Over time, however, the radiology report has expanded beyond communicating clinical results to documenting for billing and coding, compliance, and Merit-based Incentive Payment System (MIPS) information retrieval. The ONC refers to this phenomenon as “note bloat.” Radiology report is at risk of losing its value to the ordering clinician when it is used to document information for purposes other than the clinical question at hand. Also, patients are requesting access to their radiology reports. The format and language used in a radiology report are not patient-friendly. Rather than the current “one size fits all” approach of trying to serve multiple different consistencies, the EHR or other HIT system could generate multiple reports customized to the specific user. This can be accomplished through structured report templates. For starters, there would be a clinical report for the ordering clinician, one for coding and billing, and a lay-report for patients. EHR-generated reports would be

consistent with current workflows and not add burden to clinicians and each “consumer” of the radiology report would get the information they need and in the manner they want it.

### **Prior-Authorization**

Prior-authorization is a process used to determine whether a service is medically necessary. RadNet agrees with ONC’s assessment that the current prior-authorization ecosystem is challenging for clinicians, frustrating for patients, and increasingly burdensome. This burden is not limited to completing the clinical documentation to justify medical necessity and obtaining approval. As an imaging provider, our services are often subjected to prior-authorization. Prior-authorization creates delays in patient care while the clinical information for the reason for the exam is assembled and submitted (often with additional information requested) and awaiting approval which can take three to five days. Scheduling staff have to reschedule exams if the prior-authorization has not been received. Not only is this inconvenient for the patient, but disrupts our schedule. To keep this from being a routine occurrence, a significant amount of direct coordination is required with the ordering clinician’s office which adds burden and costs, respectively. Even with prior-authorization and despite our best efforts, payors will deny our claims after the fact citing prior-authorization issues thus imposing a financial hardship. Each denied claim has to be worked by staff to find out the reason, which could include need for more medical necessity, mis-matched prior-authorization numbers, and different procedures authorized vs. performed.

Ideally, medical necessity determinations should be a seamless automated transaction involving ordering clinicians, payors, and rendering providers and covering the continuum of care from order through payment. Optimizing electronic workflows, advancing new standards, and automating prior-authorization processes are steps in the right direction with respect to reducing burden, costs, and delays in patient care. The electronic ordering of imaging services should be part of the solution as well. But, prior-authorization, at its core, is a manual process involving human review and there is only so much automation can do to accelerate this process.

Medicare’s Appropriate Use Criteria (AUC) program for advanced diagnostic imaging services (ADIS) is the prototype for this seamless automated appropriateness process and an alternative to traditional prior-authorization. Under the program that goes into effect on January 1, 2020, clinicians will be required to consult with approved clinical decision support (CDS) tools using recognized AUC guidelines when ordering ADIS (CT, MRI, nuclear medicine, and PET) for their Medicare patients. CDS tools can return a score of a procedure’s appropriateness based on the patient’s clinical indications instantaneously. This transaction can be automated further by integrating the CDS tool into the ordering clinician’s EHR and by utilizing electronic ordering which communicates this information to the imaging provider. We believe that AUC-based CDS tools will eventually replace traditional prior-authorization in imaging.

## Health IT Usability and the User Experience Strategies and Recommendations

### **RadLex Would Standardize Imaging Test Descriptions and Improve Usability**

The ONC report points out that EHRs can be a barrier to clinicians when it comes to ordering diagnostic tests. Long lists of possible study choices may lead to the wrong test being performed or extra communication between the ordering clinician and radiology staff to ensure the right exam. EHR developers and relevant stakeholders are called upon in the report to develop unique descriptions for imaging tests that are clear, concise, and reduce confusion.

RadLex<sup>1</sup> (RadLex Playbook) is an existing system of unique descriptions for imaging tests. The Playbook is a project of the Radiological Society of North America (RSNA) and provides a standard system for naming radiology procedures, based on the elements which define an imaging exam such as modality and body part. It contains over 75,000 terms and synonyms related to medical imaging that can be used in radiology reporting, data mining, and research. The Playbook has been incorporated in LOINC (Logical Observation Identifiers Names and Codes) which is maintained by the Regenstrief Institute.

RadLex Playbook adoption by EHR systems and CDS tools would be a significant step towards standardizing imaging test descriptions. Usability would be improved as clinicians can go between various systems more readily and confidently knowing that test descriptions will be the same regardless of platform. Clinicians and radiology staff will have better agreement on the study being requested which should promote electronic ordering and help ensure the right test is performed. Standardized imaging descriptions through RadLex would facilitate a variety of operational and quality improvement efforts too, including workflow optimization, chargemaster management, radiation dose tracking, enterprise integration, and image exchange.

## EHR Reporting Strategies and Recommendations

### **Electronic Ordering of Imaging Studies**

According to the report, EHRs have the opportunity to “serve as an interface to laboratory, imaging, and other diagnostic study results, a correspondence medium serving as a dedicated clinical e-mail system, and, importantly, a powerful tool for initiating clinician orders.” One aspect of electronic health information exchange that has been overlooked largely is the electronic ordering of imaging studies. Despite the adoption of health information systems and electronic interfaces, the vast majority of orders for imaging services, particularly in ambulatory settings like freestanding imaging centers, still are conducted on written scrips brought in by the patient or sent by fax from the referring clinician’s office. Manual entry of order information is slow, costly, and subject to error. Electronic ordering of imaging

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<sup>1</sup> <http://playbook.radlex.org/playbook/SearchRadlexAction>

studies via EHR systems will reduce this burden, increase accuracy, and communicate more information (e.g., expanded clinical indications, clinical decision support consultations). This type of interoperability will improve the timeliness of patient care and reduce the number of repeat imaging studies. To make electronic ordering a reality, it needs to be made a higher priority so that EHR vendors are incentivized to develop low-cost, user-friendly solutions. Clinicians can be incentivized to order electronically under the Promoting Interoperability performance category under MIPS.

### **Promoting Interoperability**

The report cites the lack of standardization across electronic infrastructure causing the comparatively slow integration of systems. This lack of standardization has resulted in a disjointed patchwork of health information systems so that true interoperability, that is the ability to exchange information and use it, is still out-of-reach. Moreover, interoperability should not be hospital-centric but rather multi-directional facilitating the free-flow of health information between all healthcare providers (e.g., hospitals, physicians, imaging centers) in a given area. CMS can use the MIPS program to accelerate interoperability in terms of overall volume, information exchanged, and exchange participants (e.g., clinician to clinician, hospital to clinician, clinician to hospital).

### **Open API Approach to HHS Electronic Administrative Systems**

The report recognizes that most HHS electronic administrative systems do not integrate with current HIT which wastes time and effort as clinicians have to switch interfaces in order to access or update information. The proposed solution is for HHS to implement an open API interface for its own electronic systems that use and maintain administrative information.

Medicare pays for imaging and other specific services when ordered by physicians and other eligible professionals who are enrolled in Medicare. Given the prospects of having their Medicare claims denied, the task of verifying enrollment and eligibility rests with the imaging center and other technical component (TC) imaging providers. CMS makes available to the public a file that contains the national provider identifiers (NPIs) and the names of physicians and non-physician practitioners who have current enrollment records in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) and are of a type/specialty that is eligible to order and refer. Integration with PECOS had been a source of major burden and costs. Imaging centers should not have to bear the burden of enforcing this requirement, but at least the PECOS API has made verifying enrollment records easier. We support open API for HHS administrative information.

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In conclusion, RadNet appreciates the opportunity to provide the ONC with our feedback on its report on reducing administrative and regulatory burdens in the use of HIT. If you have any questions or need additional information, please contact Michael Mabry, RadNet's Director of Public Policy and Economic Analysis at 443.810.4798 or [Michael.Mabry@RadNet.com](mailto:Michael.Mabry@RadNet.com).

Sincerely,

A handwritten signature in blue ink that reads 'Susan Hollabaugh'. The signature is fluid and cursive, with the first name 'Susan' being larger and more prominent than the last name 'Hollabaugh'.

Susan Hollabaugh  
Vice President, Regulatory Analysis and Conformance

cc: Ranjan Jayanathan, RadNet  
Michael Mabry, RadNet