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March 24, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-6098-NC
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via http://www.regulations.gov.

Dear Administrator Oz,

The American Academy of Dermatology Association (AADA) appreciates the opportunity to provide comments to the Centers for Medicare and Medicaid Services (CMS) in response to the Request for Information (RFI) Related to Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH).

The AADA represents over 18,000 dermatologists nationwide who are committed to excellence in the medical and surgical treatment of skin disease; advocating for high standards in clinical practice, education, and research in dermatology and dermatopathology; and driving continuous improvement in patient care and outcomes while reducing the burden of disease.

Program Integrity (Traditional Medicare and Medicare Advantage [MA])

The AADA recognizes the importance of combatting fraud, waste, and abuse to protect the integrity of our health care system. For instance, the AADA previously supported CMS expanding its oversight and enforcement of categories of parties affiliated with a provider/supplier.[1] While we appreciate the need for additional regulatory action to reduce fraud, we believe efforts need to be balanced to ensure patient access and high-quality care. The AADA recommends data gathering and a thoughtful data-driven strategic approach to identify bad actors, as opposed to a "one size fits all" physician oversight model going forward.

[1] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-Payment Medical Review Requirements

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Preclusion List and Medicare Advantage Enrollment Requirements

CMS seeks feedback on potential improvements to the Preclusion List and whether requiring enrollment in Traditional Medicare could enhance program integrity. While the AADA recognizes that bad actors revoked from Traditional Medicare may shift billing to MA plans, we are concerned that significant changes to Preclusion List rules could impose undue barriers on physician participation in MA networks thereby impacting access. The AADA is already concerned that MA plans do not give enough attention to network adequacy concerns as we continuously hear from patients about the long waits for dermatology appointments.

As CMS considers changes to the Preclusion List, **the AADA recommends that CMS continue to take a risk-based approach to adding providers and suppliers to the Preclusion List, rather than broadly requiring all providers and suppliers to be enrolled in Traditional Medicare in order to bill for services under the MA program.** Such an approach would balance the need to address program integrity concerns with the need to protect access to services for MA beneficiaries.

Laboratory Tests Including Genetic Tests and Molecular Diagnostic Tests (MolDX)

The Academy supports CMS's efforts to protect the Medicare program from fraud, waste, and abuse while ensuring that beneficiaries retain access to medically necessary diagnostic testing. Molecular diagnostic testing may be used in dermatologic care in situations where additional molecular information supports diagnostic evaluation, prognostic assessment, or treatment planning, including for certain skin cancers and other complex conditions.

As CMS considers potential oversight mechanisms related to laboratory testing, including molecular diagnostic testing, it is important that such approaches maintain appropriate safeguards while minimizing burdens on physicians who rely on laboratory testing to guide patient care. Oversight mechanisms should therefore be structured to support program integrity without imposing additional administrative or operational burdens on physicians.

In prior engagement with Medicare Administrative Contractors (MACs), the AADA and the Dermatology Contractor Advisory Committee (DermCAC) have worked to ensure that coverage policies under the "MolDX" program do not unnecessarily limit which physicians may order medically necessary tests. Molecular testing is often incorporated into multidisciplinary care, and policies should recognize that physicians actively involved in the diagnosis or management of a patient's condition — including those serving in a consultative role who use the results in managing the patient's condition — may appropriately order such tests when clinically indicated. Coverage policies should avoid establishing requirements that could be interpreted as limiting physician scope of practice or restricting the clinical judgment of treating physicians responsible for managing a patient's care. Physicians frequently make time-sensitive plan of care determinations based on the results of these diagnostic tests.

Transparency in the evaluation of molecular diagnostic tests is also critical to ensuring stakeholder confidence in coverage decisions. The 21st Century Cures Act established enhanced transparency requirements for the development of Local Coverage Determinations (LCDs), including public notice, stakeholder engagement, and the publication of supporting evidence. However, certain evidentiary review processes used to evaluate molecular diagnostic tests—such as Medicare Administrative Contractor (MAC) technical assessments under the MolDX program—occur outside the formal LCD notice-and-comment framework. When such assessments inform coverage policies, this limited visibility into the methodology, evidence review, or stakeholder

engagement can create uncertainty for physicians who rely on these tests in patient care. Greater transparency around these processes would help support consistent and informed coverage decision-making.

To support program integrity while maintaining access to appropriate diagnostic care, **the AADA encourages CMS to consider the following principles when evaluating laboratory testing oversight mechanisms:**

- **Preserve physician ordering flexibility by ensuring coverage policies do not unnecessarily restrict which qualified physicians may order medically necessary diagnostic tests.**
- **Promote transparency in evidentiary review processes, including technical assessments that may inform coverage determinations.**
- **Minimize administrative burden on physician practices when implementing oversight mechanisms related to laboratory testing.**

These principles will help ensure that any future oversight framework supports program integrity while preserving patient access to medically necessary diagnostic testing and minimizing administrative burden for physician practices.

Medicare Parts A and B (Traditional Medicare) Claim Submissions

With regard to the filing of claims, the AADA's policy stance is that all health insurance entities – inclusive of non-profit and health maintenance organizations – should acknowledge receipt of each electronic claim within one business day, and that acceptance or rejection of the electronic claim occur within 20 business days. Furthermore, all insurance entities should pay for "clean" claims when filed electronically within 14 days, and paper claims within 30 days, with interest accruing thereafter.[2] **As CMS considers altering the existing claim filing deadline for Medicare Parts A and B, the AADA requests CMS to consider the disruption to current flexibilities related to coordination of benefits and billing during provider enrollment period.**

Artificial Intelligence (AI) in Medicare Advantage Coding Oversight and Hospital Billing

Major health insurers have deployed AI programs to expedite review of physician-submitted claims, which has the potential to promote more timely reimbursement. Payers tout such programs as a tool to ensure overpayments are not being made to physicians. Yet dermatologists report an increasing number of payers unilaterally adjusting reported Evaluation and Management (E/M) code level (downcoding) claims and reducing payment automatically using AI tools, without first requesting and reviewing clinical records that are integral to the adjudication of the claim. The AADA opposes improper payment reductions for services appropriately documented as it creates unnecessary administrative burden for practices forced to appeal improperly downcoded claims. The AADA previously responded to the Department of Health and Human Services (HHS) RFI on Accelerating the Adoption and Use of AI as Part of Clinical Care.[3] We urge CMS to review the AADA's recommendations on the use of AI, with specific focus on AI in MA coding oversight medical record review. **We recommend that CMS enhance its regulatory oversight of MA use of AI-driven payer downcoding and develop guidelines for best practices on using AI in claims review**. **Recommendations for best practices include using AI as the first step to review and flag claims billing trends and patterns suspected of inappropriate coding, followed by appropriate human examination by those in the same**

[2] AADA Position Statement on Filing of Claims
[3] See the AADA's comment letter responding to HHS's RFI: Accelerating the Adoption and Use of AI as Part of Clinical Care

specialty as the billing physician. MA plans should also ensure transparency with clinicians regarding tools utilized in any audits with ongoing evaluation of AI in claims review.

CMS is urged to encourage MA plans to take a progressive data-driven, risk-based approach for addressing potential billing errors. For example, MA plans should first educate clinicians regarding negative trends and billing patterns that are flagged, with education spanning at least 6 months in order to provide physician practices sufficient time to comply. As a next step, MA plans might implement a targeted review program only for bad actors based upon these publicly shared billing trends and patterns once education has been completed.

We appreciate the opportunity to provide comments on reducing fraud, waste, and abuse without adding unnecessary burdens to physicians and undermining patient care. If you have any questions regarding this letter, please contact Elizabeth Boyes, Senior Manager, Health Policy & Payment, at eboyes@aad.org or 847-240-1289.

Sincerely,

Susan C. Taylor, MD, FAAD
President, American Academy of Dermatology Association