

January 28, 2021

Liz Richter
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-IFC
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/ Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID-19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID-19

Dear Acting Administrator Richter:

The American College of Radiology (ACR), representing more than 40,000 diagnostic radiologists, interventional radiologists, radiation oncologists, nuclear medicine physicians and medical physicists, appreciates the opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2021 Medicare Physician Fee Schedule (MPFS) Final Rule.

Evaluation and Management (E/M) Services

Policy

For CY 2021, CMS is building on changes it finalized last year to reduce administrative burden, improve payment rates, and reflect current clinical practice. CMS will adopt the new coding structure for the office/outpatient E/M codes as recommended by the American Medical Association (AMA), as well as the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC)-recommended times and values.

ACR Perspective and Comments

The ACR appreciates CMS' commitment to reducing physician burden and documentation requirements. We also support the AMA's purposeful approach to restructuring and revaluing the office-based E/M codes and the concordant increases in primary care payments these updates shall provide.

To achieve the main goal above, one of the guiding principles established by the CPT/RUC Workgroup was, "To ensure that payment for E/M is resource-based and that there is no direct goal for payment redistribution between specialties." Despite this assertion, the opposite has occurred largely because of the sheer volume with which the office-based codes are billed compared to other specialty services, such as radiology. The ACR recognizes that the intent of this effort was not this massive redistribution of MPFS payments.

The Consolidated Appropriations Act, 2021 modified the CY 2021 Medicare Physician Fee Schedule and provided a 3.75 percent increase in the MPFS payments for CY 2021. However, the ACR still remains deeply concerned about the sizable cuts the E/M update will continue to impose upon radiology and other medical specialties who do not frequently bill E/M codes. This will have a devastating impact to the medical community and ultimately negative impact to the patients, especially during the COVID-19 pandemic. As such, the ACR ask that CMS revisit the impacts in the 2022 rulemaking cycle. In addition, there should be a ceiling and a floor threshold in terms of percent increase/decrease in payment in a given year.

The implementation of the add-on code G2211 for complex E/M visits has been delayed until CY 2024. The ACR reiterates our belief that this code remains unnecessary. CMS' intent is to ensure payment for outliers to the typical patients described by the newly revised office visit codes. However, the revised office codes (e.g., code 99215) are already designed to capture this complexity. The revised descriptor for G2211 [*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)*] continues to be poorly defined. We are concerned that the ambiguity of this code and the implicit direction from CMS that it be added to every, or nearly every, office visit creates integrity issues for CMS.

If implemented, the creation of this unnecessary code will needlessly redistribute billions of dollars between specialties at a time when those specialties that do not bill E/M codes face struggles with the massive redistribution triggered by changes in payment for the above-described office based E/M codes. The ACR recommends that CMS not move forward with G2211 in CY 2024.

Scope of Practice: Supervision of Diagnostic Tests

Policy

CMS finalized its proposal to amend the rule to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) or certified nurse-midwives (CNMs) to supervise diagnostic tests on a permanent basis as allowed by state law and scope of practice.

ACR Perspective and Comments

As stated in our comments on the proposed rule, the ACR does not support the relaxation of supervision regulation to allow NP, CNS, PA, and CNMs to supervise diagnostic tests. To prevent the spread of COVID-19 and provide the highest quality patient care, radiographic interpretations and supervision can be provided following appropriate social distancing measures via teleradiology/telecommunication. Allowing PAs and advanced practice registered nurses (APRNs) to supervise diagnostics tests presents unnecessary risks for patients and beneficiaries. These new policies take major steps to move patient care away from a physician-led team and more towards allowing PAs and APRNS to work in independent practice. For radiological care, this could be very detrimental to patients. Supervision of diagnostic tests is a vital step in maintaining high quality. The skill set for selecting the most appropriate exam, protocoling that exam and evaluating the quality of a diagnostic exam (all part of “supervision”) requires years of focused training and experience, and is best performed by a physician skilled in interpreting such a study. The vast majority of diagnostic tests should be primarily supervised by radiologists. Lastly, no NPP should ever be allowed to interpret images and none are meant to be trained to work in independent practice.

Loosening CMS’ national policies on the supervision of NPPs and more broadly deferring to state law and scope of practice could detract from quality patient care. Currently, at the state level there are many laws that allow APRNs to perform and interpret X-rays under general supervision. From a medical training and malpractice perspective, this is a dangerous path to take regarding quality patient care and patient safety.

That said, the ACR is concerned that supervision rules are not consistent across practice settings, leaving some providers at a disadvantage. Regulations for Independent Diagnostic Testing Facilities (IDTFs) impose more stringent requirements on who can supervise tests than is now required in other outpatient imaging centers, such as physician offices and hospital outpatient departments. Specifically, the “proficiency” requirements for supervising physicians contained in the program integrity requirements for IDTFs found at 42 CFR 410.33(b)(2) state, “The supervising physician must be proficient in the performance and interpretation of each type of

diagnostic procedure performed by the IDTF.” Additionally, IDTFs are required to submit attestations regarding such proficiency to their local Medicare Administrative Contractor (MAC) with signatures from each supervising physician.

The ACR requests clarification from CMS on whether there was an intent to maintain the supervision requirements within the IDTF regulations and applications or if there was an oversight in the failure to reflect the changes finalized in the MPFS that allow non-physician practitioners (NPPs) to supervise diagnostic tests in the IDTF setting.

In addition, the revised Code of Federal Regulations language in §410.32(b)(3) that allows NPPs to supervise diagnostic tests only appears under the section for direct supervision, but general and personal supervision levels as written still require physician supervision. The ACR recommends that CMS limit general supervision to qualified physicians. Pursuant to the Medicare Improvements for Patients and Providers Act of 2008, since 2012, suppliers of advanced diagnostic imaging services must be accredited. Accrediting organizations such as the ACR effectively require that only qualified physicians act as the medical director and general supervising physician in accredited imaging facilities.

Valuation of Specific Codes

Lung Biopsy-CT Guidance Bundle (CPT code 32408)

CPT codes 32405 (*Biopsy, lung or mediastinum, percutaneous needle*) and 77012 (*Computed tomography guidance for needle placement (eg, biopsy, aspiration, injection, localization device), radiological supervision and interpretation*) were identified on a screen for codes reported together 75% or more of the time. The CPT Editorial Panel then created a new code, 32408 (*Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed*)), bundling these services. CMS disagreed with the RUC-recommended 4.00 RVU for CPT code 32408, indicating that the value overstates the increase in intensity given the decrease in time. CMS believes there is some overlap in physician work that is not reflected in the RUC-recommended RVU, but provides no insight as to why this may be the case. Instead, CMS has finalized 3.18 RVU for CPT code 32408, which is the sum of the current RVUs for the component codes: 32405 at 1.68 RVU and 77012 at 1.50 RVU.

We are disappointed by, and disagree strongly with, the value implemented by CMS and their rationale for doing so. The work in the base code, 32405, has changed since it was last valued in 2010 based on changes in clinical needs and tissue pathology to guide oncologic therapy. This was discussed in detail at the RUC and was included in the compelling evidence rationale. For this reason, the survey data and code comparisons are the most appropriate method of assessing the work in the current code bundle, not the values of the component codes. The MPC and KRS comparisons for the new code, 32408, clearly support the RUC valuation of 4.00 wRVU.

The ACR appreciates CMS’s acceptance of the PE inputs.

Screening CT of Thorax (CPT codes 71250, 71260, 71270, and 71271)

HCPCS code G0297 (*Low dose ct scan (ldct) for lung cancer screening*) was identified on a CMS/Other screen for codes with 2017 Medicare utilization over 30,000. The RUC referred the code to the CPT Editorial Panel, which created a new CPT code for this procedure, 71271 (*Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)*). CT chest codes 71250 (*Computed tomography, thorax; without contrast material*), 71260 (*Computed tomography, thorax; with contrast material(s)*), and 71270 (*Computed tomography, thorax; without contrast material, followed by contrast material(s) and further sections*), were also addressed as part of the larger code family.

CMS disagreed with the RUC-recommended values (displayed in table below) and applied intraservice time ratios to refine the values for the code family for CY 2021. The ACR strongly disagrees with the CMS rationale for adjusting the values throughout this family, as this disregards the survey data regarding intensity of the services presented, as well as the recent 2016 survey data. A one-minute difference in the intra-service times between the current and a very recent 2016 survey is hardly a justification for significant valuation changes when the work has not fundamentally changed. All of the current and recommended values were at or below the 25th percentile survey values. The KRS selections (CT Abdomen family) of the surveyees clearly indicate the times and values recommended for the CT Thorax family to be consistent across the CT family of codes (see chart below).

CPT Code	Descriptor	wRVU	Pre Time	Intra Time	Post Time	TOTAL Time	IWPUT	Source	RUC Meeting Date
71250	Computed tomography, thorax, diagnostic; without contrast material	1.16	3	14	3	20	0.073		October 2019
71271	Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)	1.16	3	15	3	21	0.068		October 2019
74150	Computed tomography, abdomen; without contrast material	1.19	3	12	5	20	0.084	RUC	April 2014
71260	Computed tomography, thorax, diagnostic; with contrast material(s)	1.24	4	15	3	22	0.072		October 2019
74160	Computed tomography, abdomen; with contrast material(s)	1.27	3	15	5	23	0.073	RUC	April 2014
71270	Computed tomography, thorax, diagnostic;	1.38	5	18	4	27	0.065		October 2019

	without contrast material, followed by contrast material(s) and further sections								
74170	Computed tomography, abdomen; without contrast material, followed by contrast material(s) and further sections	1.40	5	18	5	28	0.065	RUC	April 2014

The ACR is also disappointed that CMS maintained their refinements to the practice expense for CPT code 71271. CPT code 71271 requires 2 additional minutes (6 minutes instead of 4 minutes) to coordinate post-service procedures for the CT technologist to generate a letter that must be sent to each patient with their results and follow-up instructions. The follow-up exams are scheduled with the patient based on the interpretation of the most recent exam. This time also includes adding patient information to a registry and ensuring that it is verified, as required by CMS regulation. All lung cancer screening patients must be tracked. Additionally, as part of registry reporting, there is mandatory management of LCS program quality metrics with requisite chart and data entry review.

We also feel that the additional minute (3 minutes instead of the 2 standard minutes) is appropriate for the CT technologist to review the questionnaire and confirm that there have been no changes in the patient’s clinical status that would make him/her ineligible for screening CT (e.g. symptoms have developed in the interval since the exam was scheduled). Also, additional information is required from the patient for registry reporting (including cancer history, prior occupational and environmental exposures, etc). In addition, time is spent with the patient to educate him/her on the process for screening, including the need for follow-up exams.

The ACR appreciates the opportunity to provide comments on the CY 2021 MPFS final rule. We encourage CMS to continue to work with physicians and their professional societies throughout future rulemaking processes in order to create a stable and equitable payment system. The ACR looks forward to continued dialogue with CMS officials about this important issue in order to



ensure continued Medicare beneficiary access to vital healthcare services. If you have any questions or comments on this letter or any other issues with respect to radiology or radiation oncology, please contact Angela Kim at 800-227-5463 ext. 4556 or via email at akim@acr.org.

Respectfully Submitted,

A handwritten signature in black ink, which appears to read "William T. Thorwarth, Jr.", is written below the text "Respectfully Submitted,".

William T. Thorwarth, Jr, MD, FACR
Chief Executive Officer

cc: Cynthia Moran, ACR
Angela J. Kim, ACR
Kathryn Keysor, ACR