May 29, 2020

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS–1744–IFC
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244-1850

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

Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

Dear Administrator Verma:

The American College of Radiology (ACR), representing nearly 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 Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE) Interim Final Rule (IFC). The College appreciates the added flexibilities during this unprecedented time which allow our members to care for patients in the most safe and efficient manner possible. We note in comments below, thoughts and concerns about extending some of these flexibilities beyond the duration of the PHE.

Direct Supervision by Interactive Telecommunications Technology

Interim Final Rule Policy

CMS indicates a belief in the IFC that the direct supervision requirement would limit access to procedures and tests that could be appropriately supervised by a physician isolated for purposes of limiting exposure to COVID-19. Therefore, CMS has altered the definition of direct supervision to allow, for the duration of the PHE for the COVID-19 pandemic, direct supervision to be provided using real-time interactive audio and video technology. The agency states that telecommunications technology could be used so the physician is immediately available to furnish assistance and direction without necessarily requiring the physician’s physical presence in the location where the service is being furnished. CMS also notes that the supervision requirements that apply to both services incident to a physicians’ service and diagnostic tests do not necessarily reflect the appropriate level of supervision for particular patients, services, and health care workers. CMS views supervision levels as the minimum possible requirement for provision of the service for purposes of Medicare
payment. CMS is seeking comments as to whether there should be any guardrails and what kind of risk this policy may introduce for beneficiaries while reducing risk of COVID-19 spread.

ACR Perspective and Comments

The ACR supports the use of telecommunications technology to provide supervision of clinically appropriate physician services and diagnostic tests as a means to decrease exposure and spread of COVID-19 during the PHE. We generally support the use of telecommunication technologies to prevent the spread of COVID-19, but stress the importance of having necessary physicians and staff immediately available for assistance if needed. *After the PHE declaration ends, the ACR asks that CMS carefully analyze the overall decision to allow for direct supervision, as well as the specific clinical scenarios where allowed, through the use of interactive telecommunications technology. There may be circumstances where a lower level of supervision may compromise patient safety.*

Physician Supervision Flexibility for Outpatient Hospitals - Outpatient Hospital Therapeutic Services Assigned to the Non-Surgical Extended Duration Therapeutic Services (NSEDTS) Level of Supervision

Interim Final Rule Policy

In the calendar year (CY) 2020 Hospital Outpatient Prospective Payment System (HOPPS) final rule, CMS changed the generally applicable minimum required level of supervision for most hospital outpatient therapeutic services from direct supervision to general supervision for hospitals and critical access hospitals (CAHs). On an interim basis during the PHE, CMS will change the minimum applicable level of supervision for all outpatient hospital therapeutic services to general supervision, in accordance to the change in the CY 2020 HOPPS final rule.

ACR Perspective and Comments

The ACR has significant concerns about the decision to expand the policy to change the generally applicable minimum required level of supervision for all outpatient therapeutic services from direct supervision to general supervision. Ancillary clinical personnel such as nurses and other staff working in the hospital are an essential part of physician-led health care teams. Their education, training, and experience equip them to play an integral role in patient care, but it does not substitute for intensive and specialized training that physicians, including radiologists, radiation oncologists and nuclear medicine physicians receive.

In general, the ACR supports temporary efforts to allow safe distancing and lessen transmission of COVID-19. *However, the ACR believes that CMS should require direct supervision for outpatient therapeutic services in the hospital outpatient setting following the conclusion of the public health emergency.* The ACR believes that CMS should not compromise quality patient care and safety by allowing outpatient therapeutic services to be performed without direct physician supervision.
Change to Medicare Shared Savings Program (MSSP) Extreme and Uncontrollable Circumstances Policy

Interim Final Rule Policy

CMS has declared that for the performance year (PY) 2020 financial reconciliation, the agency will reduce an accountable care organization’s (ACO) shared losses by an amount determined by multiplying the shared losses by the percentage of the total months in the performance year affected by an extreme and uncontrollable circumstance and the percentage of an ACO’s beneficiaries that reside in an affected area. Additionally, CMS has determined that the factors used to update ACOs’ benchmarks will reflect national and regional trends related to spending and utilization changes during 2020, including changes due to the COVID-19 pandemic.

ACR Perspectives and Comments

The ACR appreciates that CMS recognizes concerns surrounding the COVID-19 pandemic and the impacts it will have on MSSP participants. However, the ACR believes that for PY 2020 of the MSSP, CMS should eliminate downside risk, thus waiving shared losses, and benchmark data should not be created during the duration of the PHE.

Furthermore, the ACR supports recent letters sent to the Administrator from Senator Whitehouse and Senator Cassidy, as well as the Medicare Payment Advisory Commission (MedPAC). In their letter to the Administrator, Senators Whitehouse and Cassidy urge CMS to waive the shared loss repayment for ACOs for PY 2020. MedPAC has similarly urged the Administrator not to use 2020 data to determine ACO performance for purposes of computing ACO quality, bonuses, or penalties. The ACR agrees with the recommendations not to use 2020 data to determine ACO performance for purposes of computing ACO quality, bonuses, or penalties.

Site of Service Differential for Medicare Telehealth Services

Interim Final Rule Policy

CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the place of service (POS) code that would have been reported had the service been furnished in person. This will allow their systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. Many of the assumptions that support the PFS facility rate do not apply to many services during the COVID pandemic. CMS is finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth.
ACR Perspectives and Comments

Given the need to minimize exposure to COVID-19, the ACR understands the great value of telehealth during the PHE. *Once the PHE is over, the ACR urges CMS to consider how continued telehealth claims processing shall be administered in the future and how representative payments shall be determined. Specifically, the ACR asks that all payments for Medicare services should be resource based with appropriate work relative value units reflecting time and intensity, as well as appropriate practice expense inputs.*

Medicare Telehealth Expansion for On-Treatment Visits (OTVs)

*Interim Final Rule Policy*

In the interim final rule, the agency broadens the application of telehealth to include in-person, face-to-face interactions associated with radiation oncology on-treatment visits (OTVs) as described under CPT Code 77427 – Radiation Treatment Management, 5 treatments.

ACR Perspectives and Comments

The ACR appreciates CMS’ agreement that the weekly face-to-face visit component of this service can be conducted via telehealth, particularly when the physician weighs the COVID-19 exposure risks against the value of an in-person assessment on a case-by-case basis. *Therefore, the College supports CPT code 77427 for inclusion on the list of approved telehealth services during the PHE declaration.*

Application of Certain National Coverage Determination (NCD) and Local Coverage Determination (LCD) Requirements During the PHE for the COVID-19 Pandemic

*Face-to-face and In-person Requirements*

*Interim Final Rule Policy*

During the PHE for the COVID-19 pandemic CMS is finalizing that to the extent an NCD or LCD (including billing and coding articles) would otherwise require a face-to-face or in-person encounter for evaluations, assessments, certifications or other implied face-to-face services, these requirements would not apply.

ACR Perspectives and Comments

The ACR supports CMS efforts to extend flexibility on face-to-face requirements. We understand these changes are temporary and do not preclude a group practice or physician from meeting the clinical indications of coverage criteria.
Requirements for Consultations or Services Furnished by or with the Supervision of a Particular Medical Practitioner or Specialist

Interim Final Rule Policy

As staffing is being adjusted in both facility and non-facility settings to accommodate the needs of patients during the PHE for the COVID–19 pandemic, staffing decisions may impact the availability of physicians and physician specialists to furnish evaluations, consultations and procedures or to supervise others. To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish a service, procedure or any portion thereof, CMS is finalizing on an interim basis the chief medical officer or equivalent of the facility can authorize another physician specialty or other practitioner type to meet those requirements during the PHE for the COVID-19 pandemic. Additionally, to the extent NCDs and LCDs require a physician or physician specialty to supervise other practitioners, professionals or qualified personnel, the chief medical officer of the facility can authorize that such supervision requirements do not apply during the PHE for the COVID-19 pandemic.

ACR Perspectives and Comments

The ACR appreciates CMS recognizing providers may be reassigned during the COVID-19 pandemic and the need for practice leaders to make decisions to address staffing concerns to achieve coverage and supervision requirements and meet patients’ needs. The College urges CMS to reinstate all NCD and LCD specialty and supervision requirements when the PHE has ended.

Request to Revise Treating Physician Rule for Radiologists

The ACR asks that CMS update the Medicare Benefit Policy manual provision that limits the scenarios in which radiologists may act as a “treating physician” and order Medicare covered diagnostic tests. The ACR believes that this provision creates an unwarranted disparity in how radiologists are treated relative to primary care physicians and other physician specialists, and that this disparity is inhibiting high quality and efficient delivery of patient care. The ACR respectfully requests that CMS take action to remove this unwarranted limitation on radiologists. The College believe that CMS’s current treating physician rule is an impediment to the equitable and efficient access to such care.

The ACR requests that CMS update the treating physician rule to include the following language: “A radiologist is considered a treating physician if the radiologist uses the results of the diagnostic test as part of the management of a beneficiary’s specific problem, regardless of whether the radiologist would perform a therapeutic interventional procedure or would refer the performance of such interventional procedure to another physician specialist, if the findings from the test ordered by the radiologist demonstrated the medical necessity of the interventional procedures.”

This request builds upon ACR’s April 1, 2020 “Request to Revise CMS Guidance Regarding the Treating Physician Rule for Radiologist” letter to CMS. This request is made more critical due to the current COVID-19 pandemic and PHE.
The ACR appreciates the opportunity to provide comments on this IFC. We encourage CMS to continue to work with physicians and their professional societies to develop policies that allow physicians needed flexibilities to provide safe and efficient care during the PHE and to determine the best way to return to a “new normal” when the PHE has ended. 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 Kathryn Keysor at 800-227-5463 ext. 4950 or via email at kkeysor@acr.org.

Respectfully Submitted,

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Chief Executive Officer