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Carole Schwartz, DFO
Advisory Panel on Hospital Outpatient Payment
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
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Submitted electronically: APCPanel@cms.hhs.gov

Dear Ms. Schwartz:

The American Society for Radiation Oncology (ASTRO), American Brachytherapy Society (ABS), American Association of Physicists in Medicine (AAPM) and the American College of Radiology appreciate the opportunity to provide written comments to the Advisory Panel on Hospital Outpatient Payment on the methodologies used to develop Comprehensive Ambulatory Payment Classifications (C-APC) and Ambulatory Payment Classifications (APC) in the Hospital Outpatient Prospective Payment System (HOPPS).

In this letter we provide an overview of general concerns, as well as specific concerns, regarding existing C-APCs and APCs. Our organizations are interested in pursuing additional data analysis to further pinpoint the methodological inconsistencies in the development of C-APCs and APCs that warrant further attention. Once that analysis is complete we will share that information with the panel in an effort to work collaboratively on the development of C-APCs and APCs that more accurately reflect the value of the services delivered to patients in the hospital outpatient setting.

ASTRO members are medical professionals practicing at hospitals and cancer treatment centers in the United States and around the globe. They make up the radiation treatment teams that are critical in the fight against cancer. These teams include radiation oncologists, medical physicists, medical dosimetrists, radiation therapists, oncology nurses, nutritionists and social workers. They treat more than one million cancer patients each year. We believe this multi-disciplinary membership makes us uniquely qualified to provide input on the inherently complex issues related to Medicare payment policy and coding for radiation oncology services.

The American Association of Physicists in Medicine (AAPM) is the premier organization in medical physics, a broadly-based scientific and professional discipline encompassing physics principles and applications in biology and medicine whose mission is to advance the science, education and professional practice of medical physics. Medical physicists contribute to the

effectiveness of radiological imaging procedures by assuring radiation safety and helping to develop improved imaging techniques (e.g., mammography CT, MR, ultrasound). They contribute to development of therapeutic techniques (e.g., prostate implants, stereotactic radiosurgery), collaborate with radiation oncologists to design treatment plans, and monitor equipment and procedures to insure that cancer patients receive the prescribed dose of radiation to the correct location. Medical physicists are responsible for ensuring that imaging and treatment facilities meet the rules and regulations of the U.S. Nuclear Regulatory Commission (NRC) and various State regulatory agencies. AAPM represents over 7,000 medical physicists.

Founded in 1978, the American Brachytherapy Society (ABS) is a nonprofit organization that seeks to provide insight and research into the use of Brachytherapy in malignant and benign conditions. The mission of the ABS is to benefit patients by providing information directly to the consumer, by promoting the highest possible standards of practice of Brachytherapy, and to benefit health care professionals by encouraging improved and continuing education for radiation oncologists and other health care professionals involved in the treatment of cancer. Additionally, the ABS seeks to promote clinical and laboratory research into the frontiers of knowledge of the specialty and to study the socioeconomic aspects of the practice of Brachytherapy. The organization consists of approximately 1,500 physicians, medical physicists, and other health care providers interested in Brachytherapy.

The American College of Radiology (ACR), founded in 1924, is a professional medical society dedicated to serving patients and society by empowering radiology and radiation oncology professionals to advance the practice, science and professions of radiological and radiation oncological care. The ACR represents over 36,000 members, drawn from radiologists, radiation oncologists, medical physicists, interventional radiologists, and nuclear medicine physicians. For over three quarters of a century, the ACR has devoted its resources to making imaging safe, effective and accessible to those who need it.

General Comments

Comprehensive Ambulatory Payment Classifications (C-APCs) Methodology

CMS finalized the policy for comprehensive APCs (C-APCs) in the 2014 Hospital Outpatient Prospective Payment System (HOPPS) final rule. Under the C-APC policy, CMS provides a single payment for all services on the claim regardless of the span of the date(s) of service. Conceptually, the C-APC is designed so there is a single primary service on the claim, identified by the status indicator (SI) of J1. All adjunctive services provided to support the delivery of the primary service are included on the claim. The payment is calculated to capture the costs associated with all of these services.

The C-APC advances CMS' desire to establish a single bill for a service rather than individual bills for the components of that service. The APCs will count all items on the same claim (across multiple days) to be part of the service package and will thus not render separate payment for conditionally packaged codes or other services (with the exception of preventative care) that appear anywhere on the same claim. CMS believes this will improve the validity of payments to

more accurately reflect true costs, reduce administrative burden, and improve transparency for the beneficiary, physicians, and hospitals.

We support the agency's efforts to develop a payment system that promotes efficiency and high quality care. However, it is critical that such a system accurately value the cost of the constituent services needed to provide the primary procedure. **We believe that the proposed methodology used to determine C-APC payments remains flawed.** We are concerned that claim processes very greatly across organizations and that the administrative burden of managing claims based on specific procedure codes will not be feasible. **As such, we are concerned that the current C-APC methodology lacks the appropriate charge capture mechanisms.**

Restructuring APCs

In the final 2016 HOPPS rule, CMS finalized the restructuring and renumbering of many of the HOPPS APC groupings. We applaud CMS' efforts to create a more intuitive system, however, the methodology to create these new groupings needs further refinement. We are concerned that the new groupings result in having one driving code (i.e. utilization over 1,000) in an APC and then sporadic placement of lower frequency codes and other factors leading to "two times rule" violations. It is critical that CMS apply the longstanding "two times rule" methodology to the new groupings.

CMS should work closely with stakeholders to ensure transparency in the creation and refinement of C-APCs, so that providers understand the changes and requirements. Ensuring the accuracy of hospital cost data and the reliability of reimbursement, including the maintenance of the two times rule, is paramount to the success of this payment system.

Specific APC Methodology Concerns

CPT Code 77300

We believe there is a problem with the way CMS is handing data for CPT Code 77300. CPT Code 77300 is a bypass code and remains separately paid for some claims, but is not separately payable for other claims (i.e. brachytherapy). We believe this had led to inappropriate charge capture/programming in the HOPPS data system.

CMS isolates bypass codes early on in their programming, ensuring the lines aren't there when they are calculating the single-procedure claims costs. That methodology works if those lines are going to continue to be separately paid. However, if those lines are going to be packaged, then they must remain on the claims, or those charges are lost and they not reflected in rate setting for services where they will not be separately payable (i.e. brachytherapy).

As such, we believe the 2016 (and subsequently 2017) methodology for handling CPT code 77300 is wrong and needs to be updated immediately to ensure the charges for 77300 are appropriately captured in services where they are not separately payable (i.e. brachytherapy).

Brachytherapy

HDR Brachytherapy – APC 5622 and APC 5641

In the final 2016 HOPPS rule, CMS finalized its decision to assign the new and revised HDR Brachytherapy codes to APCs 5622 and 5624

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate
77767	HDR Skin Surface Brachytherapy	NP	S	5622	2.6362	$194.35
77768	HDR Skin Surface Brachytherapy	NP	S	5622	2.6362	$194.35
77770	HDR Intracavitary Brachytherapy, Simple	NP	S	5624	9.4433	$696.21
77771	HDR Intracavitary Brachytherapy, Intermediate	NP	S	5624	9.4433	$696.21
77772	HDR Intracavitary Brachytherapy, Complex	NP	S	5624	9.4433	$696.21

CMS rejected recommendations that the agency revise its methodology to include the cost of the dose calculation (77300) that is now bundled into the HDR Brachytherapy codes. See 77300 section above.

CMS should recalculate the geometric mean cost for HDR Brachytherapy codes 77767-77772 to include the cost of a dose calculation (i.e. 77300).

Specific C-APC Methodology Concerns

C-APC 5631 Single Session Cranial Stereotactic Radiosurgery

In the final 2016 HOPPS rule, CMS finalized its proposal to revise payment for C-APC 5631 by removing planning and preparation services from the C-APC geometric mean calculation for 2016 and 2017. According to the final rule, those services included "CT Localization (CPT codes 77011 and 77014), MRI (CPT codes 70551, 70552, and 70553), **Clinical Treatment Planning (CPT codes 77280, 77285, and 77290)**, and Physics Consultation (CPT codes 77336)." Hospitals are also required to use a HCPCS modifier on all services related to single session cranial stereotactic radiosurgery to assess the costs of all related adjunctive services.

Single session radiosurgery is often comprised of work over multiple days or weeks and frequently along with other courses of therapy. Organizations typically structure claims based on time periods and managing the application of modifiers or specifying procedures for a particular claim is a significant bureaucratic burden that we fear many organizations will not implement correctly. While we support CMS's efforts to better capture the costs of adjunctive services involved in

providing primary services, we believe that the addition of an even more complex system of modifiers will not bring accuracy to the data collected nor clarity to the payment process.

We are concerned with CMS claims processing/data capture for C-APC 5631. We would like CMS to explain the methodology for charge capture when codes not listed above appear on a claim. For example – how will CPT Code 77300 be handled? **See 77300 section above.** How will other radiation oncology services (like CPT 77301) that may appear on claims, not listed in the rule be handled? We believe these charges will be lost.

The recent experience with bundling related to this comprehensive APC has been unnecessarily complex and has clearly caused both confusion and inaccuracy in coding for stereotactic radiosurgery procedures. **CMS should convene stakeholders in 2016 to discuss the goals of this C-APC process and develop recommendations as to how those goals could realistically be achieved. Additionally, we request clarification regarding the services CMS is removing from the C-APC. The final rule states "Clinical Treatment Planning" but then proceeds to list a series of simulation codes "77280, 77285, and 77290".**

SRS/SBRT

Stereotactic Body Radiation Therapy (SBRT) – CPT Code 77373

In the final 2016 HOPPS, CMS modified its proposal to assign CPT code 77373 to proposed new APC 5625 *Level 5 Radiation Therapy* by assigning the code to new APC 5626 *Level 6 Radiation Therapy*. CPT code 77373 is the only procedure code assigned to APC 5626 and will be reimbursed at a rate of $1,672, a 12 percent reduction over the 2015 rate. We are concerned that that serious coding anomalies exist in the HOPPS claims data, which indicates that some hospitals are coding CPT code 77372 for the first fraction of a multiple session of SBRT, instead of billing 77373. **We urge CMS to further examine claims data to identify and address the anomalies that result in these yearly declines.**

IMRT Planning and Simulation

We continue to be extremely concerned with the HOPPS payment methodology for CPT Code 77301 IMRT Planning. Currently, the methodology does not account for the simulation work associated with the code.

CPT code 77290, *Therapeutic radiology simulation-aided field setting*, was bundled into CPT code 77301 when last reviewed by the RUC. CPT code 77301 was assigned to the same APC as CPT code 77295, 3-*D conformal planning*, which does not include simulation. These are not clinically coherent APCs.

In addition, CPT Code 77300 is an issue for this service as well. **See 77300 section above.** We believe the charges for 77300 have been lost for these services as well.

We urge the Panel to work with stakeholders and CMS to analyze the methodology for these services and assign CPT Code 77301 to a higher valued APC for 77301 that will recognize the additional resources associated with this service.

Thank you for the opportunity to provide comments on the C-APC and APC methodologies. We look forward to sharing additional analysis regarding these concerns and potential solutions for resolving issues. We hope these future opportunities will result in modifications that can be supported by the Panel. Should you have any questions on the items addressed in this comment letter, please contact Anne Hubbard, ASTRO Director of Health Policy, at 703-839-7394 or anne.hubbard@astro.org; Wendy Smith Fuss, ABS and AAPM, at 561-637-6060; or Pamela Kassing, ACR at 800-227-5463 ext. 4544.

Respectfully,

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