

September 23, 2004

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1429-P
P.O. Box 8012
Baltimore, MD 21244-8012

RE: CMS-1429-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005

Dear Dr. McClellan:

The American Society for Therapeutic Radiology and Oncology (ASTRO)^[1] appreciates the opportunity to provide comments on the Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005 announced in the *Federal Register* on August 5, 2004. Our comments focus on (1) the nonphysician work pool; (2) submission of supplemental surveys; (3) repricing of clinical practice expense inputs-equipment; (4) the change in global period for CPT code 77427, *Radiation Treatment Management, five treatments*; (5) elimination of CPT[®] code 79900 *Provision of therapeutic radiopharmaceutical(s)*; and (6) the Sustainable Growth Rate (SGR).

Nonphysician Work Pool [69 Fed. Reg. 47,491]

The technical component services are critical for the treatment delivery aspects of radiation oncology. Delivery of radiation treatments to cancer patients is a team effort with many nonphysician members providing highly skilled services. The nonphysician work pool takes into account those services provided by nonphysician staff. As you know, the specialty of radiation oncology receives 65 percent of its Medicare payments from services that are affected by the nonphysician work pool, or NPWP, calculations.

This year, as part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Congress enacted provisions that would alter the payment methodology for chemotherapy drugs and administration. This proposal would effectively remove chemotherapy administration services from the NPWP, and the CMS methodology is such that the removal of these codes from the NPWP would lead to a decrease in practice expense relative value units for all of the remaining services, including radiation oncology.

ASTRO received commitments from health care committee leaders on Capitol Hill that their intent was to hold other specialties in the pool “harmless” when changes in the pool were made due to average

¹ *The American Society for Therapeutic Radiology and Oncology is the largest radiation oncology society in the world with more than 7,500 members who specialize in treating patients with radiation therapies. As a leading organization in radiation oncology, biology and physics, the Society's mission is to advance the practice of radiation oncology by promoting excellence in patient care, providing opportunities for educational and professional development, promoting research and disseminating research results and representing radiation oncology in a rapidly evolving socioeconomic healthcare environment. Nearly two-thirds of all cancer patients receive radiation therapy during their illness. Medicare/Medicaid is the predominant source or reimbursement for radiation oncology procedures.*

wholesale price (AWP) changes. In report language (§ 303(a) of the Conference Agreement) accompanying the MMA, this understanding was codified.

“The Secretary is required to make adjustments to the non-physician work pool methodology so that the practice expense relative values for other services in the pool are not affected by the changes to practice expenses for drug administration. This provision is intended to protect the services in the non-physician work pool from payment reductions resulting from changes made to the AWP payment methodology.”

In addition, ASTRO and its physician leaders received a commitment from Administrator Scully and his staff that if the Centers for Medicare and Medicaid Services (CMS) implements regulations to address the practice expense payments for chemotherapy administration, it would be done in a manner that protects the practice expense payments for radiation oncology and other services remaining in the nonphysician work pool from any reductions.

We noted that the practice expense RVUs for 33 of the 36 radiation oncology technical component services that are in the nonphysician work pool are proposed to be reduced in 2005. The proposed practice expense RVUs for the remaining 3 codes are unchanged. Although the changes are small with a range of change from -0.01 to -0.15 RVUs, the collective impact across all the services provided by our members and others who provide these services could be significant. We hope that these reductions were not tied to the medical oncologists coming out of the nonphysician workpool. We ask that CMS clarify this issue in the Final Rule.

Submission of Supplemental Surveys [69 Fed. Reg. 47,492]

We appreciate the opportunity to provide CMS supplemental practice expense data survey for radiation oncology. Our membership is always eager to provide additional information and our response rate for the supplemental survey was evidence of that support. We understand that CMS will not be using the data from our supplemental survey in 2005, as our data did not meet the CMS precision criteria. Currently, we are working with the CMS contractor (The Lewin Group) and our contractor in an effort to further analyze the data. The specific practice patterns and practice environment of radiation oncology may preclude our data, regardless of our response rate, from ever being able to meet the established CMS precision criteria. We look forward to working with CMS over the next year to further analyze our data and explore alternatives, such as the possibility of modifying the precision criteria or to allow an exception in a case such as ours.

Repricing of Clinical Practice Expense Inputs-Equipment [69 Fed. Reg. 47,494]

We are responding to your request that specialty groups provide the necessary pricing information, including appropriate documentation, for several radiation oncology items. More specifically, we have reviewed Table 2.-Equipment Items Needing Specialty Input For Pricing And Proposed Deletions, Table 3.-Proposed Practice Expense Supply Item Additions For 2004 and Table 4.-Supply Items Needing Specialty Input For Pricing. From Table 2, there were 16 items we identified relating to radiation oncology, as well as two hyperthermia supplies listed in Table 3 and 4 that need price information. We are providing documentation per this request, including a list of price quotes for each of the items. (See Attachments 1 & 2) Additional backup material (i.e., copies of invoices or catalog with pricing information) will be sent under a separate letter to maintain confidentiality of those who provided ASTRO with this documentation. For those items that do not have a specific invoice, one will be forwarded as soon as possible. We are working with our members to provide this information to CMS promptly. We strongly request that CMS maintain these radiation oncology items proposed for deletion as they remain necessary items for the practice of radiation oncology. It is imperative that radiation

oncologists receive reimbursement for these items in order to maintain essential treatments for their patients.

Coding-Global Period [69 Fed. Reg. 47,510]

CMS proposes to change the global period for procedure code 77427, “Radiation treatment management, five treatments” from “xxx” (meaning that the global indicator concept does not apply) to “090” (meaning that there is a 90-day global period). CMS stated in the preamble to the proposed rule that the global indicator should be 090 “since the RUC’s valuation of this service reflected a global period of 90 days and we accepted this valuation.” 69 Fed. Reg. 47,510. ASTRO disagrees that this was the RUC’s intention or recommendation. We look forward to clarifying this issue with CMS.

It is our understanding that the implication of this global period change, if adopted by CMS, is that any visit services provided in the 90-day global period related to procedure code 77427 following the submission of a claim for procedure code 77427 will no longer be eligible for separate payment. We are unclear if this change would include claims for 77427. CMS noted in the preamble that it reviewed Medicare data and found that physicians rarely bill for services during the 90-day period following the date-of-service for procedure code 77427. 69 Fed. Reg. 47,567. CMS stated it believes this proposal will have little effect on Medicare program expenditures and payments to physicians.

ASTRO requests clarification regarding the implications for claims submitted for procedure code 77427. If CMS intends to limit reimbursement to one 77427 claim per 90 days, ASTRO strongly objects to this significant change in policy and would ask that it be withdrawn. Such a policy would not recognize the nature of this procedure. Radiation therapy is given sequentially over varying periods of time. For many types of cancer, radiation therapy usually is given 5 times a week for 5 to 8 weeks. Since the typical patient receives therapy five days per week, code 77427 is typically submitted on a weekly basis. If CMS changes the global period from “xxx” to “090,” the carriers’ claims processing systems may reject all claims submitted within 90 days of the first date of service for code 77427, including subsequent claims for 77427 that are submitted within 90 days of the first week of therapy. This would be inappropriate and highly disruptive. Medicare processed over 1.4 million claims for procedure code 77427 in 2003. We do not believe CMS intended such a change in policy, and we look forward to discussing this issue with you further.

We would note that the only exceptions to the CMS global policy that precludes payment for services during the postoperative period are for services that are billed with one of the following modifiers:

- **-25:** *Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service;*
- **-58:** *Staged or Related Procedure or Service by the Same Physician During the Postoperative Period;*
- **-78:** *Return to the Operating Room for a Related Procedure During the Postoperative Period; and*
- **-79:** *Unrelated Procedure or Service by the Same Physician During the Postoperative Period.*

None of these modifiers seem appropriate for use with code 77427 since radiation therapy management is not a surgical procedure with a post-operative period. Even if CMS were to create a new modifier or issue instructions to use one of the existing modifiers, we are very concerned that the proposed policy, without appropriate clarification, could lead to inappropriate denials because physicians would not understand the

need to use a modifier in order to receive payment. For these physicians, it would be inconceivable to think that subsequent weeks of radiation therapy management are part of the first week's management. Accordingly, physicians would need to resubmit claims or file appeals for denied claims. In either case, it would increase administrative costs for both physicians and carriers.

As noted above, CMS refers in the preamble to the proposed rule that the "xxx" global indicator is incorrect based on the RUC valuation. When CPT code 77427 was valued by the RUC, we believe this bundling of evaluation and management (E/M) and other services was understood and accounted for in the recommended value submitted, to and accepted by CMS.

If CMS' intention was to limit separate payment for office visits using, for example, E/M codes, CMS should provide additional clarification. It has been longstanding Medicare policy to bundle the payment for E/M and many other services related to radiation treatment management into code 77427. In this regard, Section 70.2 (Services Bundled Into Treatment Management Codes) of Chapter 13 (Radiology Services and Other Diagnostic Procedures) of the Medicare Claims Processing Manual (CMS Pub. 100-4) lists the codes for which separate payment is not made in addition to payment for code 77427. This policy is implemented through the Correct Coding Initiative which includes 116 codes for the bundled services described in Section 70.2 of the Manual. Further, any claims for E/M or other related services that are submitted during the course of radiation therapy are rejected by the CCI edits.

ASTRO strongly urges CMS to clarify this issue. We look forward to working with you in this area.

Q Code for the Set-Up of Portable X-Ray Equipment [69 Fed. Reg. 47,513]

We understand that CMS is considering removing the Q code for the set-up of portable X-ray equipment, Q0092, from the nonphysician workpool. This code generated a high volume of payments (approximately \$19 million) last year. ASTRO requests that CMS protect the radiation oncology codes that remain in the nonphysician workpool from any reduction as a result of removing this code from the NPWP.

Elimination of CPT[®] code 79900 *Provision of therapeutic radiopharmaceutical(s)*

It is ASTRO's understanding that CPT[®] code 79900 *Provision of therapeutic radiopharmaceutical(s)* will be eliminated effective January 1, 2005, based on an American Medical Association (AMA) CPT Editorial Panel recommendation. CPT code 79900 is used to bill brachytherapy sources and several radiopharmaceuticals under Medicare Part B in the physician office/freestanding radiation oncology center and ambulatory surgical center (ASC) settings. It has been suggested that a Healthcare Common Procedure Coding System (HCPCS) code would be more appropriate than a CPT code.

With the elimination of CPT 79900, there is no way to provide Medicare reimbursement to providers who perform this service in a freestanding radiation oncology center or ASC setting. Activating HCPCS code Q3001 *Radioelements for brachytherapy, any type*, and assigning a status indicator of "A" may be a viable option, if that change is made concurrently with the elimination of CPT Code 79900. It does not appear that Q3001 will be an active code in the 2005 Medicare Physician Fee Schedule Final Rule, based on this Proposed Rule. ASTRO requests that CMS delay the deletion of CPT code 79900 for one year, until an alternative coding mechanism is in place.

Sustainable Growth Rate (SGR) [69 Fed. Reg. 47,490]

ASTRO urges CMS to revise the current SGR system to more accurately reflect the practice expenses of healthcare and make the necessary changes to prevent any further reductions in the Medicare physician payment update factor due to the fundamental flaws in the update formula.

Long-term, systemic flaws in the Medicare physician reimbursement formula include, but are not limited to:

- * Linking Medicare physician fees to the Gross Domestic Product which does not accurately reflect changes in the cost of caring for Medicare patients;
- * Including the costs of Medicare-covered outpatient drugs and biologicals in setting the expenditure target for physicians' services, even though these items are not physicians' services and therefore, under the formula, lead to decreases in the payment update;
- * Inadequately accounting for changes in the volume of services provided to Medicare patients due to new preventive screening benefits, national coverage decisions that affect the demand for services, a greater reliance upon drugs to treat illnesses, and a greater awareness of covered health benefits and practices due to educational outreach efforts; and
- * Improper accounting for the costs and savings associated with new technologies.

An additional problem is the current update formula's built-in "zero tolerance" for variance between growth in the general economy and growth in the medical sector, so one year of uneven growth requires an immediate recoupment and a potentially large reduction in the following year's update. Furthermore, the adjustments made in accordance with the formula are asymmetrical and can result in a cut in the update as great as 7 percent, but allow a potential increase of only 3 percent, creating unstable and inequitable swings in reimbursement.

Unless CMS refines the update formula, we will continue to see inappropriate and unsustainable reductions for several years. As previously stated, ASTRO strongly urges CMS to make the necessary changes to prevent any further reductions in the Medicare physician payment update factor due to the fundamental flaws in the update formula. ASTRO looks forward to reading the complete discussion of the CMS methodology for calculating the SGR in the final rule.

Conclusion

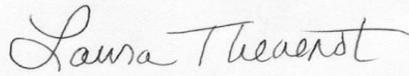
ASTRO applauds the CMS staff for their efforts to use more current data and to make more information available to the public in the proposed, rather than the final rule. Our recommendations include the following:

- (1) Maintain the current status that includes radiation oncologist specialty in the nonphysician work pool;
- (2) Work with ASTRO to further analyze the radiation oncology supplemental survey data and possibly consider modifying the precision criteria or allow an exception for acceptance of the data;
- (3) Clarify the implications of CMS' proposal to apply the 090 period to CPT code 77427 will not affect the submission of multiple claims for procedure 77427 during this period;
- (4) Maintain necessary equipment and supplies in the practice expense;
- (5) Delay in the implementation of eliminating CPT code 79900 or activation of Q3001 as of January 1, 2005; and
- (6) Revision to the current SGR system to more accurately reflect the practice expenses of healthcare.

The American Society for Therapeutic Radiology and Oncology appreciates the opportunity to offer these comments and looks forward to working with CMS to address these important issues. If you require

further information, please contact Trisha Crishock, MSW, Director, Health Policy and Economics Department at (703) 502-1550.

Respectfully,

A handwritten signature in cursive script that reads "Laura Thevenot". The signature is written in black ink on a light-colored, slightly textured background.

Laura Thevenot
ASTRO, Executive Director

cc: Trisha Crishock
Herb Kuhn
Ken Simon, MD
Edith Hambrick, MD
Marc Hartstein
Carolyn Mullen
Pam West

Enclosed:

Attachment 1: Table 2. – Equipment Items Needing Specialty Input For Pricing And Proposed Deletions

Attachment 2: Table 4. – Supply Items Needing Specialty Input For Pricing

Attachment 1

Table 2.—Equipment Items Needing Specialty Input For Pricing And Proposed Deletions

	Equipment Code	2005 Description	CMS Price Listed in NPRM	Primary specialties associated with item	CPT code(s) associated with item	Source Identifier	Price Quote
1		Computer software, MR/PET/CT fusion	\$60,000	Radiation oncology	77301	Source A	\$60,000
						Source H	\$60,000
2	E51022	Computer system, record and verify	\$60,000	Radiation oncology	77418	Source A	\$146,500
						Source B	\$180,686
3	E51050	Computer workstation, 3D teletherapy treatment planning	\$221,500	Radiation oncology	77300, 77305, 77310, 77315, 77321, 77331	Source A	\$239,400
						Source B	\$263,496
						Source C	\$292,000
						Source H	\$230,000
4		Computer, server		Radiation oncology	77301	Source A	\$24,700
						Source A	\$28,800
						Source H	\$15,000
5	E51072	HDR Afterload System, Nucletron—Oldelft ¹	\$375,000	Radiation oncology	77781-84	Source A	\$279,000
						Source A	\$229,500
						Source D	\$461,789
						Source D	\$534,072
6		Hyperthermia system, ultrasound, external	\$360,000	Radiation oncology	77600	Source E	\$360,000
7		Hyperthermia system, ultrasound, intracavitary	\$250,000	Radiation oncology	77620		Pending

¹ Oldelft no longer applies to this equipment. It is the name of a company that Nucletron purchased approximately 10 years ago.

Attachment 1 (cont'd)

Table 2.—Equipment Items Needing Specialty Input For Pricing And Proposed Deletions

8		IMRT Physics Tools	\$55,485	Radiation oncology	77301, 77418	Source B	\$94,100
						Source B	\$63,702
						Source H	\$78,000
9		Orthovoltage radiotherapy system	\$140,000	Radiation oncology	77401		Pending
10		OSHA ventilated hood	\$5,000	Radiation oncology	77334		Pending
11		Radiation treatment vault	\$550,670	Radiation oncology	774XX	Source G	\$1,291,040
						Source J	\$585,779
						Source K	\$442,493
12		Radiation virtual simulation system		Radiation oncology	77280, 77285, 77290, 77402-16	Source A	\$967,000
13		Source, 10Ci Ir 192	\$22,000	Radiation oncology	77781-84	Source A	\$46,900
						Source D	\$43,752
14	E51005	Strontium-90 applicator	\$8,599	Radiation oncology	77789	Source A	\$4,070
						Source F	\$3,907
						Source I	\$12,137
15	E13635	Video camera	\$1,000	Radiation oncology	77418	Source B	\$18,239
16	E13635	Water chiller (radiation treatment)	\$28,000	Radiation oncology	77402-16	Source B	\$29,965
						Source B	\$21,165

Attachment 2

Table 4.—Supply Items Needing Specialty Input For Pricing

	Supply Code	2005 Description	Unit	Unit Price	Primary specialties associated with item	CPT code(s) associated with item	Source Identifier	Price Quote
17	SL008	Catheter, hyperthermia, closed-end.	Item		Radiation oncology	77600-20	Source F	\$20
18	SL008	Catheter, hyperthermia, open-end.	Item		Radiation oncology	77600	Source F	\$20