ASTRO
TARGETING CANCER CARE

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Dr. Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
ATTN: CMS-1850-P
P.O. Box 8016
Baltimore, MD 21244-8016

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

Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency, CMS-1850-P

Dear Administrator Oz:

The American Society for Radiation Oncology (ASTRO)[1] appreciates the opportunity to comment on the Calendar Year (CY) 2027 Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. The proposed rule updates the payment policies, payment rates, and quality provisions for services furnished under the HOPPS, effective January 1, 2027.

In the following letter, ASTRO seeks to provide input on the policy change proposals that have a significant impact on radiation oncology. Key issues addressed in this letter include:

- Payment for radiation treatment delivery services, with a particular focus on CPT code 77407
- Brachytherapy sources and the Low Volume APC policy
- Comprehensive Ambulatory Payment Classifications
- Diagnostic radiopharmaceutical separate payment
- Payment for software as a medical service
- Site-specific payment policy for imaging without contrast services furnished in excepted off-campus provider-based departments

[1] *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 patients with cancer 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.*

Payment for Radiation Therapy Services

ASTRO appreciates that CMS continues to recognize the importance of appropriately valuing radiation oncology services under the HOPPS. **ASTRO's primary recommendation is that CMS assign CPT code 77407 to APC 5623, *Level 3 Radiation Therapy*.** ASTRO raised this recommendation in its CY 2026 HOPPS comments and reiterates it for CY 2027 because the current APC assignment does not adequately reflect the complexity and resource use of the services now described by CPT code 77407.

The revised CPT code 77407 describes radiation treatment delivery using a single isocenter photon technique, including imaging guidance when performed. In practical clinical terms, this code captures a broad range of common radiation oncology services that previously would have been reported using now-deleted intensity modulated radiation therapy (IMRT) delivery codes or other treatment delivery codes. ASTRO's CY 2026 comment letter identified multiple disease sites that now map to revised 77407, including prostate, right breast, anus, bladder, bone, brain, colon, central nervous system, esophagus, head and neck, rectum, sarcoma, thyroid, and other sites.

ASTRO continues to support assigning 77407 to APC 5623 because deleted codes 77385 and 77386 (IMRT) described services that are more closely aligned with the resources now reflected in the revised treatment delivery family than historical data associated with the old 77407 descriptor. What is more, prior to the 2026 coding revisions, IMRT codes 77385 and 77386 were assigned to the same APC: APC 5623 (Level 3 Radiation Therapy).

ASTRO is particularly concerned that maintaining CPT code 77407 in APC 5622 undervalues a service that represents a substantial share of modern external beam radiation treatment delivery. Under the revised code family, technique alone does not determine code selection. Instead, code selection is based on complexity and specific patient and clinical characteristics. The complexity of IMRT varies depending on the treatment area, number of targets, differential doses delivered, and the technique used.

The CY 2027 OPPS proposed rule underscores the stakes of proper APC assignment. Under CMS' proposal, the APC containing CPT code 77407, APC 5622, would have a proposed CY 2027 payment rate of $460.55, while APC 5623, which includes CPT code 77412, would have a proposed CY 2027 payment rate of $640.75 (a 39% difference). Maintaining 77407 in APC 5622 therefore continues to create a meaningful payment gap between the services described by 77407 and the clinical and resource intensity ASTRO believes the revised code reflects.

ASTRO also notes that HOPPS APC assignments have consequences beyond the hospital outpatient setting. CMS now uses the relationship among the relative weights of APCs 5621, 5622, and 5623 to inform Medicare Physician Fee Schedule practice expense valuation for CPT codes 77402, 77407, and 77412. An inaccurate APC assignment for 77407 therefore risks creating distortions not only in HOPPS payment but also in the practice expense valuation of radiation treatment delivery services in the freestanding setting. The impact of this already has contributed to staff layoffs and has limited the ability of freestanding centers to invest in new equipment, while raising concerns about future access to care.

ASTRO's March 2026 member survey underscores the real-world consequences of inadequate payment for radiation treatment delivery services. Although CMS estimated that the CY 2026

coding and payment changes would reduce radiation oncology payments by approximately 1% overall, more than two-thirds of surveyed radiation oncologists reported reimbursement declines of 10% or greater, with many practices reporting cuts in the 20-30% range. Respondents described significant financial strain, including staff layoffs, hiring freezes, payment delays, claim denials, and concerns that continued reductions could force clinics to close, consolidate, or limit services. These impacts are especially concerning because radiation therapy is often delivered daily over several weeks, making local access essential for patients with cancer.

A 2026 study published in the *International Journal of Radiation Oncology • Biology • Physics* further demonstrates the fragility of the nation's radiation oncology infrastructure, finding that 68.5% of U.S. counties, representing 50.8 million people, lacked a radiation oncology practice site in 2025, and that 427 counties experienced a net loss of practice sites from 2018 to 2025. The study found that rural sites had 44% higher odds of disappearance than urban sites, and freestanding sites had 56% higher odds of closing than hospital-affiliated sites, with counties lacking radiation oncology access also more likely to have lower incomes, higher uninsurance rates, and fewer primary care physicians per capita. These findings demonstrate that inaccurate valuation of radiation treatment delivery services threatens not only practice stability, but also Medicare beneficiaries' ability to access timely, guideline-concordant cancer care close to home.

For these reasons, ASTRO urges CMS to reassign CPT code 77407 to APC 5623, Level 3 Radiation Therapy, for CY 2027.

Brachytherapy Sources and the Low Volume APC Policy

ASTRO supports CMS' continued application of the Low Volume APC policy to brachytherapy APCs. In the CY 2022 final rule, CMS adopted the Low Volume APC policy to reduce payment volatility for APCs with fewer than 100 single claims available for rate setting purposes. Under the policy, CMS determines APC cost using the greatest of the geometric mean cost, arithmetic mean cost, or median cost based on up to four years of claims data.

Based on claims data available for the CY 2027 proposed rule, CMS proposes to designate five brachytherapy APCs as low volume APCs under the OPPS. These APCs meet its criteria of having fewer than 100 single claims in the claims' year used for ratesetting (APC 2645 (Brachytx, nonstranded, gold-198) has 87 single claims and now meets CMS' criteria to be designated as a low volume APC).

Proposed Low Volume APCs Using Comprehensive Ratesetting Methodology for CY 2027

APC	APC Description	CY 2025 Claims Available for Ratesetting
2634	Brachytx, non-str, HA, P-103	28
2642	Brachytx, stranded, c-131	41
2643	Brachytx, non-stranded, c-131	78
2645	Brachytx, non-stranded, gold-198	87
2647	Brachytx, NS, Non-HDRIR-192	13

ASTRO agrees that low utilization can result in wide year-to-year variation in payment rates, especially for brachytherapy sources. The Low Volume APC policy is an important tool to mitigate payment volatility and preserve beneficiary access to brachytherapy. **Accordingly, ASTRO supports CMS' proposal to continue applying the Low Volume APC policy to the proposed brachytherapy APCs for CY 2027.**

Comprehensive Ambulatory Payment Classifications (C-APCs)

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.

While ASTRO supports policies that promote efficiency and the provision of high-quality care, we remain concerned that the C-APC methodology lacks the appropriate charge capture mechanisms to accurately reflect the services associated with the C-APC.

For example, when tandem and ovoid placement (CPT code 57155) is performed in an operating room (OR) under anesthesia, it is assigned Medicare status indicator J1 and generates a comprehensive APC payment. If the HDR treatment delivery (CPT code 77771) is delivered during that same hospital outpatient encounter, Medicare expects the HDR treatment delivery and most related facility services to be packaged into the payment for 57155.

What is more, guideline concordant care for cervical cancer requires five insertions of a tandem and ovoid device to achieve a curative outcome. The Medicare Claims Processing Manual does not provide clear guidance regarding how hospital-based practices should bill for *repetitive* services included in the C-APC methodology. Data indicates that many hospitals are not billing per encounter for tandem and ovoid insertions.

The CMS Manual System Pub 100-04[2] addresses the Frequency of Billing to Fiscal Intermediaries (FIs) for Outpatient Services. However, the publication does not address billing associated with services that are included in a C-APC. The publication states *"repetitive Part B services furnished to a single individual by providers who bill FIs should be billed monthly (or at the conclusion of treatment)."* The publication goes on to address radiation therapy service:

Revenue codes usually reported for chemotherapy and radiation therapy are not on the list of revenue codes that may only be billed monthly. Therefore, hospitals may bill chemotherapy or radiation therapy sessions on separate claims for each date of service. However, because it is common for these services to be furnished in multiple encounters that occur over several weeks or over the course of a month, hospitals have the option of reporting charges for those recurring services on a single bill, as though they were repetitive services. If hospitals elect to report charges for recurring, non-repetitive services (such as chemotherapy or radiation therapy) on a single bill, they must also report all charges for services and supplies associated with the recurring service on the same bill.

[2] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/dwnlds/R2092CPpdf.pdf

ASTRO has engaged with CMS regarding billing for CPT code 57155 as part of the C-APC methodology. The Agency has indicated that services delivered over multiple patient encounters can be reported per encounter. Per the Agency's recommendation, ASTRO has contacted the Medicare Administrative Contractors (MAC) to ask for guidance or clarification for billing for brachytherapy insertion codes that are included in the C-APC payment methodology, but the MACs' responses have indicated that no guidance publications will be forthcoming.

ASTRO encourages CMS to issue an MLN Matters Publication (or other guidance) to clarify that services assigned a J1 indicator and delivered over multiple patient encounters may be reported per encounter.

Diagnostic Radiopharmaceuticals Separate Payment

ASTRO appreciates CMS' continued separate payment for high-cost diagnostic radiopharmaceuticals and its continued recognition that packaging high-cost diagnostic radiopharmaceuticals can create barriers to beneficiary access. For CY 2027, CMS proposes to continue separate payment for diagnostic radiopharmaceuticals exceeding the packaging threshold and to increase the threshold from $655 to $665 per day. CMS proposes to continue paying qualifying diagnostic radiopharmaceuticals above the threshold based on their arithmetic mean unit cost derived from CY 2025 claims data, while encouraging manufacturers to voluntarily submit average sales price information for potential future use.

Reliable payment policy is necessary to ensure that hospitals can furnish clinically appropriate radiopharmaceutical services without absorbing significant packaged costs that may not be adequately reflected in APC payment rates. However, ASTRO remains concerned that the separate payment policy is still relatively new and that continued increases to the threshold may reduce the number of diagnostic radiopharmaceuticals eligible for separate payment before sufficient experience and claims data are available.

ASTRO urges CMS to monitor the impact of the proposed CY 2027 threshold increase carefully and ensure that the threshold does not undermine the access goals that led CMS to establish separate payment for high-cost diagnostic radiopharmaceuticals in the first place.

Payment for Software as a Medical Service (SaMS)

ASTRO appreciates CMS' attention to software-based medical services with algorithmic analyses, formerly referred to as Software-as-a-Service technologies. CMS proposes an interim payment policy under which these services would be assigned to New Technology APCs while the Agency develops a longer-term payment framework.

Radiation therapy increasingly relies on sophisticated software, including algorithmic tools that support imaging, treatment planning, and treatment delivery. ASTRO supports CMS' recognition that software-based technologies can present unique payment challenges.

We appreciate that CMS has limited claims data for most of the 36 HCPCS codes it is designating as SaMS services for CY 2027 and thus is proposing to assign or reassign these services to New Technology APCs as an interim policy for CY 2027. **ASTRO recommends that CMS work with physician specialty societies as it determines various proposals for how to structure appropriate clinical APCs for SaMS in future years.** ASTRO has worked with CMS on these types

of efforts since the inception of the use of APCs for hospital outpatient payments and would be happy to provide CMS with the clinical information and cost data that it is currently lacking to create and/or identify appropriate clinical APCs for SaMS.

Site-Neutral Payment Policy for Imaging Without Contrast Services in Excepted Off-Campus PBDs

For CY 2027, CMS proposes to apply the PFS-equivalent payment rate to HCPCS codes assigned to imaging without contrast APCs and to services paid through APCs 8004, 8005, and 8007 when furnished at an off-campus provider-based department (PBD).

ASTRO opposes applying a blanket PFS-equivalent payment rate to these services absent clear evidence that the resources required to furnish them safely and appropriately in excepted off-campus PBDs are equivalent to those reflected in the PFS payment rate. As ASTRO has emphasized in other payment contexts, payment policy should be grounded in the actual resources required to furnish the service, rather than an assumption that site of service alone justifies a lower rate.

Imaging services furnished in excepted off-campus PBDs are not always interchangeable with imaging furnished in freestanding settings. Hospital outpatient departments frequently support patients with complex clinical needs, multiple comorbidities, limited transportation options, or care plans that require coordination with other hospital-based services. Reducing payment for these services could make it more difficult for hospital-based departments to maintain imaging capacity, staffing, and coordinated workflows needed to support timely care.

ASTRO is particularly concerned that the proposed policy could create patient access issues in communities where hospital outpatient departments serve as an essential source of imaging services, including rural and underserved areas and regions with limited freestanding imaging alternatives. Payment reductions may lead some off-campus PBDs to reduce service availability, consolidate imaging at more distant locations, or limit investments in equipment and personnel. These outcomes would be contrary to CMS' stated goals of promoting access to high-quality, coordinated care and could increase delays for Medicare beneficiaries.

If CMS moves forward despite these concerns, ASTRO urges the Agency to establish a payment floor or other guardrail to prevent excessive reductions in payment for affected services. At a minimum, CMS should ensure that payment does not fall below a level necessary to support continued beneficiary access to medically necessary imaging in hospital-based settings, such as the technical component payment for the service under the Medicare Physician Fee Schedule. CMS should also monitor utilization, site-of-service shifts, appointment availability, and geographic access following implementation and be prepared to modify or suspend the policy if evidence indicates that beneficiaries are experiencing delays or reduced access to imaging services.

Thank you for the opportunity to comment on the CY 2027 HOPPS Proposed Rule. ASTRO looks forward to continued collaboration with CMS to ensure that Medicare beneficiaries have access to

high-quality, innovative cancer care. Should you have any questions, please contact Adam Greathouse, Director of Health Policy, at (703) 839-7376 or Adam.Greathouse@astro.org.

Respectfully,

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