ASTRO
TARGETING CANCER CARE

251 18th St. South, 8th Floor
Arlington, VA 22202

Main: 703.502.1550 · Fax: 703.502.7852
www.astro.org · www.rtanswers.org

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Carol Blackford
Director of the Hospital and Ambulatory Policy Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Blackford,

ASTRO wishes to thank you for the opportunity to meet with you and your team regarding key issues impacting the field of radiation oncology. We appreciate that we have been able to connect with the CMS Hospital and Ambulatory Payment Group on an annual basis about these issues. This has become particularly important as we enter a new value-based payment system that will allow radiation oncology practices to fully participate in the Quality Payment Program through the pending implementation of the Radiation Oncology Model (RO Model).

Below is a summary of the key points discussed, including the importance of continuing the Medicare Physician Fee Schedule (MPFS) G codes for conventional treatment delivery, IMRT and Image Guidance during the transition to the RO Model; additional discussion points regarding billing associated with the Comprehensive Ambulatory Payment Classification (C-APC) methodology; and a summary of the issues associated with the OIG report on CPT code 77295 *3-D Radiotherapy*.

RO Model and G Code Rate Stability

As you are aware, the Centers for Medicare and Medicaid Innovation Center (CMMI) issued a proposed rule establishing the Radiation Oncology Model (RO Model), which includes a payment methodology that is tied to historic and future MPFS payment rates. We anticipate that CMMI will issue the RO Model as a final rule this spring and we look forward to assisting our membership as it transitions to a new value-based payment system this year.

The RO Model payment methodology is inextricably linked to the historic MPFS rates associated with conventional treatment delivery, IMRT and Image Guidance, which have been recognized by G codes in the MPFS since 2015 and represent roughly half of what Medicare pays for radiation oncology services under the MPFS. The payment rates for these G codes have been frozen through the passage of bipartisan legislation since 2016. This legislative freeze expired at the end of 2019, and ASTRO thanks the Agency for its decision to extend the code freeze in the 2020 MPFS final rule to continue rate stability through the initial implementation of the RO Model.

As we discussed, ASTRO has had longstanding concerns about FFS payment stability, particularly for the freestanding centers that play an important role in ensuring access to radiation

oncology care for cancer patients nationwide. The retention of the G codes and their values over the last several years has established rate stability for freestanding centers, which has allowed for the opportunity to transition to value-based payment. While ASTRO continues to support the RUC-recommended values associated with the conventional treatment delivery, IMRT and image guidance codes, we recognize that simultaneously moving to the RO Model while implementing the new code set for freestanding centers could be disruptive, particularly if some centers are required to participate in the RO Model.

With the imminent release of the RO Model final rule and the expectation that the payment methodology will be linked to historical and future MPFS payment rates, particularly through the application of a yearly trend factor, it will be critical to retain the G codes through 2021, the first full calendar year of the RO Model, to ensure continued rate stability.

C-APC Payment Methodology

We are supportive of CMS policies that promote efficiency and the provision of high-quality care. To that end, we continue to believe that component coding is necessary to account for the multiple steps in the radiation oncology process of care, particularly when multiple modalities of treatment are interdigitated within an entire course of care.

Our takeaway from the recent meeting was that CMS is committed to the C-APC methodology. If C-APC methodology remains in place, we support CMS reassigning CPT code 57155 from C-APC 5414 *Level 4* to C-APC 5415 *Level 5* **AND** allowing for a complexity adjustment to better account for the resources used in cervical brachytherapy.

We request separate payment for radiation planning and preparation services, consistent with the Stereotactic Radiosurgery (SRS) C-APC methodology.

We also request separate payment for external beam radiation therapy (EBRT). EBRT is a distinct and separate service, not an adjunctive procedure (i.e. Status Indicator - S). We would appreciate your assistance in developing guidance on this specific issue, so that we may educate our members.

OIG report on CPT code 77295 3-D Radiotherapy

Finally, we appreciate the opportunity to continue a dialogue with CMS about our concerns regarding the OIG report on CPT code 77295 *Three Dimensional Radiotherapy,* which asserts that the Agency could produce savings if related services were bundled into the code similar to the bundling associated with *77301 IMRT Treatment Planning*.

Per our discussion, the key distinction between 77295 and 77301 is that there were "building blocks" associated with the development of 77301 when it was revalued in 2014 to include CT guidance and simulation, described by CPT codes 77280-77290; however, there are no such building blocks involved in 77295. CPT code 77295 does not include simulation or the work or

practice expense associated with any other code. Thus, it would be inappropriate to bundle those services in CPT code 77295.

Again, we appreciate your time and the attention you have given to these issues. We look forward to continued opportunities to engage with you and your team. If you should have any questions or require additional information, please contact Bryan Hull, Assistant Director of Health Policy, at 703-839-7376 or Bryan.Hull@ASTRO.org.

Sincerely,

Laura Thevenot

Laura I. Thevenot
Chief Executive Officer

CC: Capt. Margorie Baldo, Division of Outpatient Care
Ing-Jye Cheng, Deputy Director, Hospital and Ambulatory Group
Ryan Howe, Director of Practitioner Services
David Rice, Deputy Director, Division of Out-Patient Care
Patrick Sartini, Health Insurance Specialist
Tiffany Swygert, Director, Division of Out-Patient Care
Gift Tee, Acting Director, Division of Practitioner Services