



December 29, 2015

Mr. Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1633-P
P.O. Box 8013
7500 Security Boulevard
Baltimore, MD 21244-8013

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

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System; Provider Administrative Appeals and Judicial Review

Dear Acting Administrator Slavitt:

The American Society for Radiation Oncology (ASTRO) appreciates the opportunity to provide written comments on the “**Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Short Inpatient Hospital Stays; Transition for Certain Medicare-Dependent, Small Rural Hospitals under the Hospital Inpatient Prospective Payment System; Provider Administrative Appeals and Judicial Review**”, published in the Federal Register as a final rule on October 30, 2015.

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.

In this letter we address a number of topics that will impact our membership and the patients they serve, including:

- **General Comments: C-APCs and Restructuring APCs**
- **CPT code 77301 IMRT Planning and CPT code 77290 Simulation**
- **Brachytherapy**
- **SRS/SBRT**
- **Outpatient Quality Reporting – OP-33 External Beam Radiotherapy for Bone Metastases**

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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.

ASTRO appreciates the agency's efforts to develop a more accurate payment system. In recent years, the HOPPS system has moved toward bundled payments, putting pressure on hospitals and physicians to eliminate redundant or inappropriate care and become more efficient. ASTRO supports policies that promote efficiency and the provision of high quality care. However, we believe the methodology used to create C-APCs remains flawed. We remain very concerned that the C-APC methodology lacks the appropriate charge capture mechanisms. It is critical that the payment bundles that CMS develops accurately reflect the services associated with the C-APC. We urge CMS to work with stakeholders as it determines an appropriate valuation for this and other C-APCs.

Restructuring APCs

In the final rule, CMS finalized the restructuring and renumbering of many of the HOPPS APC groupings. ASTRO applauds CMS' efforts to create a more intuitive system, however, the methodology to create these new groupings needs further refinement. ASTRO is 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.

ASTRO urges CMS to 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.

IMRT Planning and Simulation

CMS confirmed that IMRT planning includes simulation, reiterating its policy that the APC payment for IMRT planning services includes CPT codes 77280 through 77295. In the final rule, CMS committed to revising and updating the Medicare Claims Processing Manual and coding guidance to more directly state the policy. CMS will institute the following coding guidance:

“Payment for the services identified by CPT codes 77014, 77280 through 77295, 77305 through 77321, 77331, and 77370 is included in the APC payment for CPT code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 (on either the same or a different date of service) unless these services are being performed in support of a separate and distinct non-IMRT radiation therapy for a different tumor.”

CMS acknowledged but rejected ASTRO’s request to move CPT code 77301 to a higher APC to recognize the additional work associated with simulation. CPT code 77301 will remain in the new APC 5614 *Therapeutic Radiation Treatment Preparation Level 4*. CMS said that the final geometric mean costs of the services described by CPT code 77301 is approximately \$1,125 based on 51,301 single claims, which is comparable to the final geometric cost of approximately \$1,074 for APC 5614. CMS will continue to monitor the cost information on claims containing services described by 77301 and determine if a change in APC is warranted in the future.

ASTRO appreciates CMS’ acknowledgement of the significant amount of confusion associated with billing CPT codes 77290 and 77301. Nonetheless, given this confusion, ASTRO urges CMS not to pursue any claims audit activity associated with claims issued prior to the issuance of the 2016 final OPPTS (October 30, 2015). The confusion regarding these codes and how they can be billed is not only shared by ASTRO and its members, but also among Medicare Administrative Contractors, who continue to issue Local Coverage Determinations stating that billing 77290 with 77301 is acceptable practice.

As for the revised coding guidance, ASTRO is concerned that the CMS language is too restrictive and excludes subsequent simulations after IMRT planning is completed. Subsequent simulations may be necessary for a block verification simulation, which is important for the safe administration of radiation treatments. These are distinctly different activities from the activities in 77301. A second simulation and/or IMRT plan could also be necessary for a patient with a significant change in tumor size, or for a patient with a significant change in normal anatomy (because of significant weight change, for example). ASTRO urges CMS to revise the guidance language as follows:

"Payment for the services identified by CPT codes 77014, 77280 through 77295, 77305 through 77321, 77331, and 77370 is included in the APC payment for CPT code 77301 (IMRT planning). These codes should not be reported in addition to CPT code 77301 (on either the same or a different date of service) unless these services are being performed in support of a separate and distinct non-IMRT radiation therapy for a different tumor. when provided prior to or as part of the development of the IMRT plan. However, in some instances simulation codes

may be reported after IMRT planning for verification of the field to ensure the safe administration of the radiation treatment or to address significant changes in tumor size or body habitus. Additional simulation services, require documentation and verification of medical necessity.’

ASTRO seeks the opportunity to work with CMS to notify and educate radiation oncologists and affiliated billing and coding professionals on the appropriate billing of CPT codes 77290 and 77301.

Brachytherapy

HDR Brachytherapy – APC 5622 and APC 5641

CMS finalized its decision to assign the new and revised HDR codes to APCs 5622 and 5641

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	5641	9.4433	\$696.21
77771	HDR Intracavitary Brachytherapy, Intermediate	NP	S	5641	9.4433	\$696.21
77772	HDR Intracavitary Brachytherapy, Complex	NP	S	5641	9.4433	\$696.21

CMS rejected ASTRO’s recommendation that the agency revise its methodology to include the cost of the dose calculation that is now bundled into the CPT codes. CMS stated it bases reimbursement rates on predecessor code APC assignments until claims data is available for the new codes.

ASTRO is disappointed in CMS’ decision not to include the cost of the dose calculation in the value of the revised Brachytherapy CPT codes. The decision to base the reimbursement rates only on a portion of the predecessor code data is incongruous to the RUC process in which efforts are being made to bundle and value codes where appropriate.

Interstitial Source Application – CPT Code 77778

When not performed on the same date of service as CPT code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application*, CPT code 77778 is assigned to APC 5624 *Level 4 Radiation Therapy*. ASTRO expressed concern in its proposed rule comments that when CPT code 77778 is used to report non-prostate LDR procedures, the payment rate of \$696 is significantly less than the 2015 reimbursement rate of \$952. This marks

a continued decline in reimbursement over the last several years. Despite these concerns CMS finalized its decision to maintain the lower reimbursement rate for 2016.

ASTRO remains concerned that the reimbursement for CPT code 77778 continues to decline from year to year. ASTRO urges CMS reconsider the value of this code, particularly, in light of the fact that CPT code 77778 now includes the work associated with CPT code 77790 *Supervision and handling, loading of radiation source*. LDR Prostate Brachytherapy cannot take place until the work of supervision, handling, and loading of radiation seeds into needles has happened, and now this work will occur in the pre-service period of the new bundled code CPT 77778. CMS must consider the value of this additional work and resource utilization in CPT code 77778.

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.

CMS rejected ASTRO's recommendation that the agency assign CPT code 77373 to New Technology – Level 25 to address concerns regarding inadequate data to appropriately value resource use. CMS believes that it has adequate claims data for CPT code 77373 because multi-session SRS is not a new technology. The agency also disagreed with ASTRO's concerns 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. The agency believes that hospitals have had adequate time to educate themselves on how to appropriately report the services described by CPT code 77373.

ASTRO remains concerned that the reimbursement for CPT code 77373 continues to decline from year to year. We continue to believe that coding anomalies in the hospital setting are the source of the problem. We urge CMS to further examine claims data to identify and address the anomalies that result in these yearly declines.

C-APC 5631 Single Session Cranial Stereotactic Radiosurgery

CMS finalized its proposal to revise payment for C-APC 5631 by removing planning and preparation services, including 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) from the C-APC geometric mean calculation for 2016 and 2017. As a result, CPT codes 77371 and 77372 will experience a 25 percent reduction in reimbursement in 2016. CMS also will require hospitals to use a HCPCS modifier on all services related to single session cranial stereotactic radiosurgery to assess the costs of all related adjunctive services.

ASTRO is disappointed with CMS' decision to implement their proposal without addressing our concerns – specifically the claims data anomalies. ASTRO urges CMS to work with the field to explore opportunities to educate and inform hospital billing and coding professionals on appropriate coding for Single Session Cranial Stereotactic Radiosurgery.

Additionally, CT localization (CPT codes 77011 and 77014) is typically not a service that is rendered in combination with Single Session Cranial Stereotactic Radiosurgery. By removing the reimbursement associated with these codes from the value of APC 5631, CMS is devaluing the code inappropriately. Again, ASTRO remains concerned that the current methodology used to establish payment bundles lack the appropriate charge capture mechanisms.

OP-33: External Beam Radiotherapy for Bone Metastases (NQF# 1822)

CMS finalized its proposal to add OP-33: External Beam Radiotherapy for Bone Metastases (NQF# 1822) to the Hospital Outpatient Quality Reporting (OQR) Program beginning with the 2018 payment determination. This measure is NQF endorsed, supported by the Measure Applications Partnership (MAP), and addresses the Making Care Safer National Quality Strategy goal. CMS is adopting the measure with a modification to the proposed data submission method, requiring that all hospitals submit this measure as an aggregate data file via a Web-based tool (QualityNet).

ASTRO applauds CMS' decision to include OP-33: External Beam Radiotherapy for Bone Metastases (NQF #1822) in the Hospital Outpatient Quality Reporting Program. Radiation therapy is an effective and often underutilized therapy for the treatment of bone metastases. The inclusion of this measure will improve the utilization of the therapy and ensure that patients suffering from bone metastases experience an improved quality of life as a result of the treatment.

Thank you for the opportunity to comment on this proposed rule. We look forward to continued dialog with CMS officials. Should you have any questions on the items addressed in this comment letter, please contact Anne Hubbard, Director of Health Policy, at 703-839-7394 or anne.hubbard@astro.org.

Respectfully,



Laura I. Thevenot
Chief Executive Officer