



August 31, 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

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**” (HOPPS), published in the Federal Register as a proposed rule on July 7, 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**
- **Radiation Therapy Devices**
- **Outpatient Quality Reporting – OP-33 External Beam Radiotherapy for Bone Metastases**

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

CMS is in the process of restructuring and renumbering many of the HOPPS APC groupings. CMS is proposing changes to these groups based on the following principles: (1) improved clinical homogeneity; (2) improved resource homogeneity; (3) reduced resource overlap and (4) greater simplicity and improved understandability. While we applaud CMS' efforts to create a more intuitive system, 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.

We urge CMS to work closely with stakeholders as the agency unveils these new groupings and C-APCs. It is important 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

ASTRO is concerned with the APC assignment for CPT Code 77301 IMRT planning. CT Simulation was bundled into CPT code 77301 when last reviewed by the RUC. We believe that confusing language in the NCCI edits has led some hospitals to bill CPT code 77290 *Therapeutic radiology simulation-aided field setting, complex* and IMRT planning code 77301 when performed on different dates of service. We believe the HOPPS data for CPT code 77301 includes a variety of patterns, including some hospital

charges that reflect the CT simulation and the IMRT plan and some charges that reflect only the IMRT plan.

ASTRO urges CMS to assign 77301 to a higher APC group to reflect the additional resource utilization of CT simulation, in addition to the very resource intense IMRT planning work. Additionally, we request that a transmittal be issued with clear instructions regarding how to bill these two services when performed for the same patient. ASTRO would like the opportunity to work with CMS on this issue to educate providers to improve the quality of the HOPPS data to ensure that it accurately captures the costs associated with both IMRT planning and CT simulation.

Brachytherapy

HDR Brachytherapy – APC 5622 and APC 5641

There are five new HDR CPT codes – temporarily numbered 7778A-E. They will replace CPT Codes 77785-7. The new codes will now include the work for HDR and dose calculations (CPT Code 77300). CMS requests public comments on the proposed CY 2016 status indicators and APC assignments for new and revised Category I and III CPT Codes effective January 1, 2016. CMS proposes to assign HDR CPT codes 7778A and B to APC 5622 Level 2 *Radiation Therapy*, at a reimbursement rate of \$197.20. HDR CPT codes 7778C, D and E are proposed to be assigned to APC 5641 *Brachytherapy* with a payment rate of \$697.05.

HCPCS Code	Short Descriptor	CI	SI	APC	Relative Weight	Payment Rate
7778A	Hdr rdnc1 skn surf brachytx	NP	S	5622	2.6674	\$197.20
7778B	Hdr rdnc1 skn surf brachytx	NP	S	5622	2.6674	\$197.20
7778C	Hdr rdnc1 ntrstl/icav brchtx	NP	S	5641	9.4287	\$697.05
7778D	Hdr rdnc1 ntrstl/icav brchtx	NP	S	5641	9.4287	\$697.05
7778E	Hdr rdnc1 ntrstl/icav brchtx	NP	S	5641	9.4287	\$697.05

Although the new CPT codes bundle dose calculations, CMS did not update their methodology to allocate any costs for the dose calculations when proposing 2016 payment rates. Application of the CMS HOPPS methodology to the recalculated costs for the combination code set (i.e. 7778C/D/E + 77300) should increase payment by approximately \$75.

ASTRO urges CMS to re-examine these HDR codes to ensure that predecessor code data is captured to establish appropriate payment rates for CY2016.

Intracavitary Radiation – CPT 77761-77763

CMS proposes splitting the intracavitary radiation codes into two distinct APCs. In 2015, CPT codes 77761 *Apply intracavitary radiation, simple*, 77762 *Apply intracavitary radiation, intermediate*, and 77763 *Apply intracavitary radiation, complex* were assigned to APC 0312 *Radioelement Applications* with a payment rate of \$395.92. CMS proposes assigning CPT code 77762 to APC 5622 *Level 2 Radiation Therapy* and CPT codes 77761 and 77763 to APC 5623 *Level 3 Radiation Therapy*. CMS is proposing a 50% payment reduction for the intermediate code.

HCPCS	APC	Payment Rate	Single Frequency	Total Frequency	Median Cost	Geometric Mean Cost
77761	5623	\$518.74	7	24	\$228.58	\$307.17
77763	5623	\$518.74	22	84	\$550.49	\$630.28

After examining the HOPPS data it appears that CPT Code 77762 had no claims available for 2016 HOPPS rate setting because the total frequency was too low (N=9). **ASTRO urges CMS to assign CPT code 77762 to APC 5623 along with CPT codes 77761 and 77763 for 2016, as they are clinically similar and have reliable resource consumption.**

Interstitial radiation source application CPT Code 77778

CPT code 77778, when used for prostate LDR, is reported with C-APC 8001. However, CPT Code 77778 can be used to report non-prostate LDR procedures. In these instances, we believe the payment rate is not reflective of the resources used to provide this service. The geometric mean (\$936) is significantly higher than the payment rate of \$697, a drastic payment decrease from the 2015 payment rate of \$952. **ASTRO continues to have concern with the brachytherapy HOPPS data, the number of claims used for rate setting and the re-structuring/reassignment of services.**

SRS/SBRT

APC 5625 Multiple Session Stereotactic Body Radiation Therapy (SBRT)

In 2016, CMS proposes to reimburse APC 5625 at \$1,699, a reduction of 11% from 2015. ASTRO remains concerned with the ongoing decline in payment for multi-session SBRT. We are specifically concerned that the HOPPS data does not accurately reflect the resources used to deliver this service.

The SRS (77371 and 77372) and SBRT (77373) CPT codes have a complicated history in the HOPPS payment system. For many years, a series of G codes were required for SBRT and SRS services. These G codes delineated between linear accelerator-based vs. cobalt-based, first fraction vs subsequent fractions, and robotic vs non robotic. The coding system in HOPPS now appears very straight forward, with three CPT codes.

However, we believe serious coding anomalies exist in the HOPPS claims data, which indicates that hospitals are errantly coding for these services. The data suggests that some hospitals are coding CPT Code 77372 (APC 5631 *Single Session Cranial Stereotactic Radiosurgery*) for the first fraction of a multiple session of SBRT, instead of billing 77373 (APC 5625 *Level 5 Radiation Therapy*).

ASTRO believes that CMS has the authority to temporarily assign CPT Code 77373 to a New Technology APC, which will allow the Agency to price this technology more appropriately and consistently. We have serious concerns about the accuracy of the SBRT hospital cost data. Setting declining HOPPS payment rates based on questionable data is not appropriate. While SBRT is not a new technology, because it has widespread use and demonstrated positive outcomes, it is evolving, with ongoing refinements in application and technique. We believe this temporary assignment will help CMS reach their HOPPS goals of making payments that are appropriate for the services that are necessary for the treatment of Medicare beneficiaries.

ASTRO recommends that CMS assign CPT code 77373 to New Technology – Level 25 (\$3,500-\$4,000) for the next three years, starting in 2016. Concurrently, we request the opportunity to

work with CMS to educate hospitals on appropriate coding for SRS and SBRT. We also urge CMS to put mechanisms in place, within HOPPS programming to review these claims and ensure rates are being set with the appropriate codes.

C-APC 5631 Single Session Cranial Stereotactic Radiosurgery

CMS proposes revising payment for C-APC 5631 by removing planning and preparation services from the C-APC geometric mean calculation for 2016 and 2017. According to CMS, 2014 claims data analysis indicates different billing patterns between SRS procedures delivered using Cobalt-60-based and Linac-based technologies. CMS claims data analysis indicates that SRS delivered by Cobalt-60 typically included treatment planning services (imaging studies, radiation treatment aids, and treatment planning) and the actual SRS treatment on the same date of services reported on the same claim. Additional analysis revealed that SRS delivered by Linac-based technologies frequently included services related to SRS treatment that were provided and reported on different dates of service and billed on separate claims.

CMS proposes removing the following planning and preparation services from C-APC 5631 for 2016 and 2017:

- CT localization (CPT codes 77011 and 77014)
- MRI imaging (CPT codes 70551, 70552, and 70553)
- Clinical treatment planning (CPT codes 77280, 77285, 77290 and 77295)
- Physics consultation (CPT code 77336)

CMS proposes making a separate payment for these services during 2016 and 2017. The agency also proposes the use of a HCPCS modifier to be reported with each of these codes.

ASTRO requests language in the 2016 HOPPS final rule outlining how CMS will handle other services performed during a course of SRS (i.e. basic dosimetry, treatment devices) that are not included in the planning and preparation services listed above. As outlined above, we believe hospitals are not appropriately coding for SRS and SBRT services. We do not believe these proposed changes, including the use of a modifier for C-APC 5631, will help CMS achieve clean claims for SRS services. We recommend that CMS leave the four identified categories of services in the C-APC methodology for 2016 and work with stakeholders to improve coding for SRS and SBRT services.

Radiation Therapy Device Codes

CMS proposes reassigning CPT codes 77332, 77333, and 77334 (Radiation treatment aid(s)) to three distinct APCs. Previously, the three device codes were assigned to APC 303 *Treatment Device Construction*. In 2015, the payment rate was \$215.63. The proposed APC assignments and payment rates follow:

- APC 5611 Level 1 Therapeutic Radiation Treatment Preparation
CPT Code 77332/Payment rate = \$109.98
- APC 5612 Level 2 Therapeutic Radiation Treatment Preparation
CPT Code 77333/Payment rate = \$169.37
- APC 5613 Level 3 Therapeutic Radiation Treatment Preparation
CPT Code 77334/Payment rate = \$297.70

HCPCS	APC	Payment Rate	Median Cost	Geometric Mean Cost
77332	5611	\$109.98	\$120.61	\$125.77
77333	5612	\$169.37	\$145.93	\$148.19
77334	5613	\$297.70	\$243.19	\$244.95
77338	5613	\$297.70	\$353.88	\$395.22

ASTRO believes it is important to capture the costs associated with the varying levels of treatment device codes. Assigning all four treatment device codes to one APC is not appropriate and does not yield appropriate payment. While ASTRO believes the resources used to provide 77338 are higher than those resources used to provide 77334, we believe this change is a move in the right direction. We urge CMS to analyze the Radiation Oncology hospital data closely, while they are proposing this new re-structure/re-assignment to ensure that appropriate payment rates are set for critical services.

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

CMS proposes accepting OP-33 External Beam Radiotherapy for Bone Metastases (NQF#1822) as a new hospital Outpatient Quality Reporting (OQR) Program Quality Measure beginning with the 2018 payment determination. The measure assesses the percentage of patients (all payer) with painful bone metastasis and no history of previous radiation, who receive EBRT with an acceptable dosing schedule. An acceptable dosing schedule for satisfying this measure includes the following fractionation schemes: 30Gy/10fxns; 24Gy/6fxns; 20Gy/5fxns; or 8Gy/1fxn. The measure excludes patients who have had previous radiation to the same site; patients with femoral axis cortical involvement greater than 3 cm in length; patients who have undergone a surgical stabilization procedure; and patients with spinal cord compression, cauda equine compression, or radicular pain.

ASTRO is pleased that CMS proposes to adopt OP-33 External Beam Radiotherapy for Bone Metastases as a new hospital Outpatient Quality Reporting (OQR) Program quality measure. Clinical evidence suggests underutilization of radiation therapy for palliation of bone metastases, as some patients are not appropriately referred for 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