

December 20, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attention: CMS-1656-P
P.O. Box 8013, 7500 Security Boulevard
Baltimore, MD 21244-1850

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

Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs

Dear Administrator Verma,

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,” published in the Federal Register as a final rule on November 13, 2017.

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 seek to address key concerns with regard to the Comprehensive APC (C-APC) methodology, its impact on radiation oncology and specifically the impact on brachytherapy services as finalized in the 2018 HOPPS final rule. We are particularly concerned that despite our previous comments regarding the methodology, CMS continues to move forward with its application to radiation oncology services.

Comprehensive APC (C-APC) Methodology

CMS’ Comprehensive-Ambulatory Payment Classification (C-APC) methodology packages payment for adjunctive and secondary items, services, and procedures into the most costly primary procedure under the HOPPS at the claim level. ASTRO continues to have great concern that the one-size-fits-all C-APC methodology is poorly suited and not appropriate for radiation oncology services. Radiation oncology essentially requires component coding to account for several steps in the process of care (consultation; preparing for treatment; medical radiation physics, dosimetry, treatment devices and special services; radiation treatment delivery; radiation treatment management; and follow-up care management). Cancer treatment is complex, as

patients are often treated concurrently with different modalities of radiation therapy for different disease sites. CMS' C-APC methodology does not account for this complexity and fails to capture appropriately coded claims, resulting in distorted data leading to inaccurate payment rates that will jeopardize access to certain radiation therapy services if continued and expanded.

Hospital billing practices vary greatly in terms of submitting radiation oncology services. They can bill services daily, weekly, monthly or a variety of other algorithms they have established internally. The site of service often varies for part of the treatment, with patients receiving portions of their treatment in the hospital outpatient, office and/or ASC setting. The radiation services are also reported through multiple hospital service lines. For example, the surgery department might report a part of the service while the radiation department reports another part of the service. These reporting complexities do not lend themselves to the "per claim" C-APC methodology. Denying claims for all radiation oncology services and conducting retrospective analysis in order to establish appropriate cost data/payments will cause an undue burden on the hospitals and patients.

The current C-APC HOPPS rate setting methodologies provide an inaccurate representation of costs for radiation oncology services. Several of these issues were highlighted in ASTRO's 2015, 2016 and 2017 proposed and final rule comments. We appreciate that the Agency has chosen not to expand this flawed methodology for 2018. However, ASTRO has serious concerns with the current CMS methodology for calculating HOPPS payment rates for radiation oncology services. Below are some key concerns:

1. Using the traditional APC methodology for radiation oncology services.

ASTRO recognizes that the Agency is moving away from traditional APC methodology toward more bundled services. However, the complexity of radiation therapy claims (planning and preparation procedures, varying patterns in time prior to 'major' treatments, the potential for multiple treatment sites, site of service inconsistencies, etc) suggest that separate traditional APCs may be the most accurate way to pay for these services in HOPPS. *(Note: If CMS reverts to traditional APC methodology for radiation oncology services, the Agency will need to expand the bypass list again to ensure appropriately coded claims are used in rate setting.)*

2. Creating a modified C-APC methodology for radiation oncology services.

If CMS continues the use of C-APC methodology for radiation oncology services, the Agency must revise the methodology to adequately capture appropriately coded claims and mitigate major distortions in data. CMS may need to establish a variety of edits to (1) exclude inappropriate services and (2) capture appropriate services in rate setting because the current methodology does not achieve this goal. The Agency will also need to consider how to appropriately identify and reimburse other codes reflected in the radiation therapy process of care (planning, physics, etc).

3. Modifying the complexity adjustment methodology for radiation oncology services.

CMS only considers J1 codes in the complexity adjustment formulas. However, Radiation treatment delivery codes are assigned a status indicator S and not considered for a complexity adjustment. Radiation oncology services should not be considered “ancillary” in the complexity adjustment methodology. Further highlighting the flaw in the current C-APC methodology is the issue of twice-a-day (BID) radiation treatments. They are not considered for a complexity adjustment, which further distorts the data creating payments that do not truly recognize the actual costs.

4. Exacerbating distorted claims data for radiation oncology services.

ASTRO is concerned that when CMS chooses to maintain flawed methodologies, it leads to contaminated data, resulting in inaccurate payment rates for radiation oncology services. CMS’ current methodologies are distorting radiation oncology claims data and contributing to the erosion of the specialty. While we can appreciate CMS’ desire to implement methodologies that can be widely adapted to the house of medicine, it is clear that radiation oncology services have complexities that are not being considered.

In the 2018 HOPPS final rule, we were disappointed that the Agency finalized decisions regarding several key brachytherapy insertion C-APCs, despite evidence that the methodology is inappropriate for this particular service.

C-APCs 5165, 5302, and 5414 - Brachytherapy Insertion

In the 2017 HOPPS final rule, CMS finalized new C-APCs that described procedures for inserting brachytherapy catheters/needles and other related brachytherapy procedures, such as the insertion of tandem and/or ovoids and the insertion of Heyman capsules. In written comments, ASTRO expressed concern that claims for several of the brachytherapy device/insertion codes (CPT Codes 57155, 20555, 31643, 41019, 43241, 55920, and 58346) did not contain a brachytherapy treatment delivery code (CPT Codes 77750 through 77799). As a result, brachytherapy delivery charges were underrepresented in rate setting under the C-APC methodology. In response to ASTRO’s concerns, CMS stated that the Agency would continue to examine the claims for these brachytherapy insertion codes and determine if any future adjustment to the methodology (or possibly code edits) would be appropriate.

In the 2018 HOPPS proposed rule, CMS announced that the Agency analyzed claims that included brachytherapy insertion codes assigned to status indicator “J1” and that received payment through a C-APC. The analysis validated ASTRO’s concerns and as a result, the Agency proposes to address the issue by establishing a code edit that requires a brachytherapy treatment code when a brachytherapy insertion code is billed.

While ASTRO expressed appreciation with CMS’ efforts to capture more correctly coded claims to establish payment rates for radiation services, we urged the Agency in our 2018 HOPPS proposed rule comments to perform additional analysis and give serious consideration to returning all brachytherapy services to the traditional APC methodology. Specifically, ASTRO

urged CMS to discontinue “J1” designation and revert to status indicator “T” for CPT codes 19296, 19298, 19499, 20555, 31643, 41019, 43241, 55920, 57155 and 58346, which will allow for separate payment for insertion codes and treatment delivery codes. **ASTRO is disappointed that CMS disregarded our concerns regarding the C-APC methodology and stated that it would continue the use of the C-APC methodology for brachytherapy services. We remain steadfast in our position that the C-APC methodology does not adequately account for the various clinically appropriate pathways available for delivering brachytherapy insertion and treatment delivery services. Because the C-APC methodology does not recognize these differences in care patterns, it remains an inappropriate payment methodology.**

Composite APC 8001 – Low Dose Rate Prostate Brachytherapy

In the 2018 HOPPS final rule, CMS finalized its proposal to delete Composite APC 8001 *LDR Prostate Brachytherapy Composite*, which included CPT Code 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy*, when it is provided on the same claim as the brachytherapy treatment delivery code (CPT 77778).

Effective January 1, 2018, CPT Code 55875 will be assigned to a C-APC 5375 *Level 5 Urology and Related Procedures* with a status indicator of J1. Also included in C-APC 5375, is the new CPT Code 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed*.

ASTRO is disappointed that CMS moved forward with this decision given that we urged the Agency to retain Composite APC 8001. While ASTRO maintains that the composite payment policy supports more accurate coding and packaging when the brachytherapy insertion code (CPT 55875) is provided on the same claim as the brachytherapy treatment delivery code (CPT 77778), we appreciate the increase in reimbursement for prostate brachytherapy.

Also included in the C-APC 5375, is the new CPT Code 55874 Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed. This hydrogel spacer may be used in patients undergoing radiation therapy for prostate cancer to reduce rectal toxicity, including patients who receive brachytherapy boost. Because CPT Code 55875 has a J1 status and is in the same C-APC, the unintended consequence of this decision may be that the biodegradable material to reduce rectal toxicity as described by CPT Code 55874 will not be properly reimbursed due to the C-APC methodology. Again, we urge the Agency to consider these ramifications and how they might be rectified by reverting to traditional APCs, thus allowing for separate payment for these services.

Other C-APC Assignments

CPT Code 20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)

In the final 2018 HOPPS, CMS made the decision to move CPT Code 20555 from C-APC 5113 *Level 3 Musculoskeletal Procedures* to C-APC 5112 *Level 2 Musculoskeletal Procedures*. This was not an item addressed in the proposed 2018 HOPPS, so this came as a surprise in the final rule. **ASTRO is disappointed that CMS did not mention this C-APC assignment change in the 2018 MPFS proposed rule when it was issued in July. This would have allowed stakeholders the opportunity to consider the change and provide comments and guidance to the Agency. As a result of CMS' decision, CPT Code 20555 will be paid at \$1,350 in 2018, a 45 percent reduction from the 2017 payment amount.**

CPT Code 55920 Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application

In the proposed 2018 HOPPS, CMS proposed to retain CPT Code 55920 in C-APC 5341 *Abdominal/Peritoneal/Biliary and Related Procedures*. ASTRO urged CMS to modify the C-APC assignment noting that radiation therapy is an important adjuvant therapy for gynecological malignancies and that the vignette for CPT Code 55920 describes a gynecological implant. The Agency has agreed to move the code to C-APC 5415 *Level 5 Gynecologic Procedures*. **ASTRO is appreciative of this decision as the assignment to C-APC 5415 more appropriately reflects the geometric mean cost of CPT Code 55290.**

C-APC 5092 Level 2 Breast/Lymphatic Surgery and Related Procedures

In the 2018 HOPPS final rule, CMS is finalizing its decision to retain CPT Code 19298 *Placement of radiotherapy afterloading brachytherapy catheters into breast for interstitial; radioelement application* in C-APC 5092 *Level 2 Breast/Lymphatic Surgery and Related Procedures*. In proposed rule comments, ASTRO argued that payment in this C-APC is inadequate because it does not recognize the costs associated with the placement of the breast brachytherapy catheter or brachytherapy treatment delivery and related planning and preparation codes. However, the Agency decided to retain CPT Code 19298 in C-APC 5092 because the geometric mean cost of \$5,944 is similar to the geometric mean cost of C-APC 5092 of \$4,809 rather than the geometric mean cost of C-APC 5093, which has a geometric mean cost of \$7,383. **ASTRO is disappointed with this decision and urges the Agency to continue monitoring CPT Code 19298. Over time the geometric cost for services changes, these changes warrant C-APC reassignment in the future.**

Thank you for the opportunity to comment on this proposed rule. We look forward to continued dialogue 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