



American Association of Physicists in Medicine

One Physics Ellipse
College Park, MD 20740-3846
(301) 209-3350
Fax (301) 209-0862
<http://www.aapm.org>

August 29, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1589-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Outpatient Prospective Payment System; Proposed Rule; CMS-1589-P

Dear Administrator Tavenner:

The American Association of Physicists in Medicine¹ (AAPM) is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 30, 2012 *Federal Register* notice regarding the 2013 Medicare Hospital Outpatient Prospective Payment System (HOPPS) proposed rule. AAPM will provide comments on the geometric mean cost proposal, volume of outpatient claims used to determine payment for low dose rate brachytherapy APCs, unpackaging intraoperative radiation therapy codes, an exception to the "Two Times Rule" for proton beam therapy codes, and an added payment for non-highly enriched uranium sources.

PROPOSED GEOMETRIC MEAN-BASED RELATIVE PAYMENT WEIGHTS

CMS proposes to use the geometric mean costs of services within an APC to determine the relative payment weights of services, rather than the median costs that CMS has used since the inception of the HOPPS.

In general, we believe that the hospital outpatient claims data is flawed at best and does not provide reliable and accurate cost data. The main flaw in the HOPPS cost data is CMS's reliance on department-level detail from individual hospital cost reports when converting charges to "cost." As a consequence, data reporting at the department-level is inconsistent.

¹ The American Association of Physicists in Medicine (AAPM) is the premier organization in medical physics, a broadly-based scientific and professional discipline encompassing physics principles and applications in biology and medicine whose mission is to advance the science, education and professional practice of medical physics. Medical physicists contribute to the effectiveness of radiological imaging procedures by assuring radiation safety and helping to develop improved imaging techniques (e.g., mammography CT, MR, ultrasound). They contribute to development of therapeutic techniques (e.g., prostate implants, stereotactic radiosurgery), collaborate with radiation oncologists to design treatment plans, and monitor equipment and procedures to insure that cancer patients receive the prescribed dose of radiation to the correct location. Medical physicists are responsible for ensuring that imaging and treatment facilities meet the rules and regulations of the U.S. Nuclear Regulatory Commission (NRC) and various State regulatory agencies. AAPM represents over 7,000 medical physicists.

Substantial hospital-level discrepancies between charges on the cost report and the same charges reported on Medicare claims has been documented by CMS and its contractors (e.g., RTI). Yet CMS applies only minimal statistical screens on these hospital-specific and department-specific cost-to-charge ratios (CCRs), allowing a wide range of implausible CCR values to affect the data.

CMS has historically relied on median costs. We agree with the CMS statement that medians are generally more stable than means because they are less sensitive to extreme observations. We believe that medians are a more reasonable choice, because they ignore outlier data.

AAPM does not support the geometric mean-based relative payment weight proposal. We recommend that CMS delay this proposal for at least one year and provide additional data on the geometric mean and median cost comparison file by CPT and HCPCS codes in the 2013 final rule and again for the 2014 proposed rule so that we may better analyze the impact of this far reaching proposal.

VOLUME OF OUTPATIENT CLAIMS USED FOR RATE SETTING

AAPM appreciates the agency's efforts to include multiple procedure claims data to calculate relative payment weights by using the "same date of service" and an expanded list of "bypass" codes to provide more single and "pseudo" single claims. However, the continued reliance on single procedure claims fails to produce a statistically valid number of low dose rate (LDR) brachytherapy procedure claims for rate setting. Additional revisions to the current methodology must be explored to ensure that CMS is basing payment on a substantial number of accurate hospital claims.

APC	Single Frequency Claims	Total Frequency Claims	% of Claims Used for Rate Setting
312 Radioelement Applications	61	472	12.9%
651 Complex Interstitial Radiation Source Application	120	5,784	2.1%
8001 LDR Prostate Brachytherapy Composite	650	4,705	13.8%

INTRAOPERATIVE RADIATION THERAPY (IORT)

CMS is proposing to unpackage CPT codes 77424 *Intraoperative radiation treatment delivery, x-ray, single treatment session* and 77425 *Intraoperative radiation treatment delivery, electrons, single treatment session*, and assign them to APC 0412 *Level III Radiation Therapy* (formerly known as "APC 0412 IMRT Treatment Delivery").

Further, CMS proposes a change to the status indicator code assignment to "B" for CPT code 77469 *Intraoperative radiation treatment management*, which is nonpayable under the HOPPS beginning in 2013.

AAPM supports the CMS proposal to unpackage IORT codes 77424 and 77425 and pay them separately beginning in 2013. We also support the proposal to assign status indicator "B" to CPT 77469, which is in accordance with your current policy for other radiation management codes.

PROTON BEAM THERAPY

Historically, the two simple proton therapy codes 77520 *Proton treatment delivery; simple; without compensation* and 77522 *Proton treatment delivery; simple; with compensation* have been assigned to APC 664 *Level I Proton Beam Therapy*; and the intermediate 77523 *Proton treatment delivery; intermediate* and the complex 77525 *Proton treatment delivery; complex* codes have been assigned to APC 667 *Level II Proton Beam Therapy*.

CMS proposes to reassign simple proton therapy code 77522 to APC 667 *Level II Proton Beam Therapy* and reassign complex proton therapy code 77525 to APC 664 *Level I Proton Beam Therapy*, which creates significant payment reductions to both APC payments in 2013.

As CMS reported, there were only 3 hospital outpatient facilities (i.e., Loma Linda University Medical Center, Massachusetts General Hospital, and the Hospital of the University of Pennsylvania) that billed Medicare for proton beam therapy services in 2011. We understand that the Hospital of the University of Pennsylvania began reporting CPT 77525 beginning in 2010 and may not have been correctly reporting their costs based on the extremely low cost-to-charge ratio compared to the other facilities reporting these codes.

APCs are organized such that each group is homogenous both clinically and in terms of resource use. An APC group cannot be considered comparable with respect to the use of resources if the highest cost for a procedure in the group is more than 2 times greater than the lowest cost for a procedure in the same group (referred to as the "Two Times Rule"). The statute authorizes CMS to make exceptions to the Two Times Rule in unusual cases, such as low-volume items and services.

Since 2010, CMS has made exceptions to the Two Times Rule for proton beam therapy APC 664 *Level I Proton Beam Therapy* in 2010 and 2011; and APC 667 *Level II Proton Beam Therapy* in 2012. Simple and complex proton beam therapy services are not clinically homogenous. Therefore, they should not be placed in the same APC, despite what the cost data appear to show.

AAPM recommends that CMS maintain the current 2012 APC assignments for proton beam therapy codes 77520, 77522, 77523, and 77525 for 2013 as the data for the proposed reassignments appear to be flawed. If necessary, CMS could make an exception to the Two Times Rule for APCs 664 and 667 in 2013.

CMS should carefully review future rate setting in cases where few providers comprise the claims database, and/or where a small number of single procedure claims exist.

PAYMENT ADJUSTMENT FOR RADIOISOTOPES DERIVED FROM NON-HIGHLY ENRICHED URANIUM SOURCES

CMS proposes to make a payment adjustment for Tc-99m radioisotopes derived from non-highly enriched uranium (HEU). CMS determined that an additional payment of \$10 was based on the best available estimations of the marginal costs associated with non-HEU Tc-99m production.

AAPM supports the CMS proposal to pay hospitals for the additional cost of using Tc-99m from a non-highly enriched uranium source.

We hope that CMS will take these issues under consideration during the development of the 2013 HOPPS final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 637-6060.

Sincerely,

A handwritten signature in black ink that reads "James R. Goodwin". The signature is written in a cursive style with a large, stylized initial "J".

James Goodwin, M.S.
Chair,
Professional Economics Committee