



August 25, 2017

Seema Verma, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1678-P  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Re: Medicare Program; Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Proposed Rule; CMS-1678-P

Dear Administrator Verma:

The American Association of Physicists in Medicine<sup>1</sup> (AAPM) is pleased to submit comments to the Centers for Medicare and Medicaid Services (CMS) in response to the July 20, 2017 *Federal Register* notice regarding the 2018 Medicare Hospital Outpatient Prospective Payment System (HOPPS) proposed rule.

The AAPM will provide comments and recommendations regarding comprehensive APCs and the proposed code edit that requires a brachytherapy treatment delivery code when a brachytherapy insertion code is billed. A summary of key AAPM recommendations include:

- Oppose required code edits for brachytherapy insertion procedures.
- Discontinue the Comprehensive APC payment policy for all brachytherapy insertion codes. Alternatively, modify the C-APC methodology to pay for “J1” brachytherapy insertion but exclude all radiation oncology codes on the claim, defined as CPT codes 77261 through 77799, and make separate payment for the brachytherapy treatment delivery and related planning and preparation services in addition to the C-APC payment.
- Continue the Composite APC payment methodology in 2018 for APC 8001 Low Dose Rate Prostate Brachytherapy Composite.
- Reassign CPT 55920 and 19298 to other C-APCs, if CMS maintains the Comprehensive APC payment policy in 2018.
- Discontinue the Comprehensive APC payment policy for Single Session Cranial Stereotactic Radiosurgery codes 77371 and 77372.
- Eliminate packaging of Image Guidance Services, including CPT 76965, 77014, 77387 and 77417.

---

<sup>1</sup> 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.

## 1. Comprehensive APCs for Brachytherapy Insertion Codes & Proposed Code Edit

Since the inception of the comprehensive APC methodology, the AAPM has commented on concerns around the accuracy of claims data, as there is a great deal of discrepancy around how hospitals submit these claims. The AAPM is also uncertain as to whether the rates associated with C-APCs adequately or accurately reflect all of the procedures and costs associated with those APCs. This is of particular concern as CMS continues to expand the number of packaged and bundled services. Preliminary claims data analysis suggests that the comprehensive APCs may result in significant Medicare payment reductions for complex radiation oncology treatments.

In the 2017 HOPPS final rule, CMS finalized several new C-APCs that describe surgical 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. CMS reports that they received public comments that noted that claims that included several insertion codes for brachytherapy devices often did not also contain a brachytherapy treatment delivery code. The commenters concluded that brachytherapy delivery charges are under represented in rate setting under the C-APC methodology because a correctly coded claim should typically include an insertion and treatment delivery code combination. The commenters stated that the insertion procedure and brachytherapy treatment delivery generally occur on the same day or within the same week and therefore the services should appear on a claim together.

CMS analyzed the claims that include brachytherapy insertion codes assigned to status indicator “J1” and that received payment through a C-APC, and determined that several of these codes are frequently billed without an associated brachytherapy treatment delivery code. For 2018 and subsequent years, CMS is proposing to establish a code edit that requires a brachytherapy treatment code when a brachytherapy insertion code is billed (see Table 1).

Table 1: Comprehensive APCs Related to Brachytherapy Insertion Codes Proposed for Required Code Edits

<b>C-APC</b>	<b>CPT Codes</b>
5091 <i>Level 1 Breast Surgery</i>	19499 Unlisted breast procedure
5092 <i>Level 2 Breast Surgery</i>	19298 Breast brachytherapy button & tube catheter placement
5093 <i>Level 3 Breast Surgery</i>	19296 Breast brachytherapy balloon catheter placement
5113 <i>Level 3 Musculoskeletal Procedures</i>	20555 Placement needles/catheters into muscle and/or soft tissue for subsequent interstitial radioelement application
5153 <i>Level 3 Airway Endoscopy</i>	31643 Diagnostic bronchoscope, catheter placement
5165 <i>Level 5 ENT Procedures</i>	41019 Placement needles/catheters into head and/or neck region for radioelement application
5302 <i>Level 2 Upper GI Procedures</i>	43241 Upper GI endoscopy, catheter placement
5341 <i>Abdominal/ Peritoneal/ Biliary Procedures</i>	55920 Placement needles/catheters into pelvic organs and/or genitalia (except prostate) for radioelement application
5375 <i>Level 5 Urology Services</i>	55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy
5414 <i>Level 4 Gynecological Procedures</i>	57155 Insertion uterine tandem and/or vaginal ovoids 58346 Insertion of Heyman capsules for clinical brachytherapy

The episode of care for cancer is complex, especially as it relates to brachytherapy treatment. We agree that most brachytherapy insertion procedures and brachytherapy treatments occur on the same day or within the same week and therefore the services should appear on the same claim. However; in other cases, the needles or catheters are surgically placed prior to the brachytherapy treatment delivery, which often consists of multiple fractions over several days or weeks and may be delivered at a different site of service than the needle or catheter insertion.

The AAPM and other stakeholders contracted with Christopher Hogan, Ph.D. of Direct Research to conduct analysis of 2016 outpatient claims regarding the 2018 CMS proposal to require a code edit for select brachytherapy insertion codes. Based on previous research and our comments regarding the 2017 HOPPS proposed rule, we initially thought that implementing a code edit would improve hospital coding and ensure more accurate payment for some C-APCs related to brachytherapy.

Based on our 2016 outpatient claims data analysis, with the exception of CPT 55875, the majority of the brachytherapy insertion codes have very low claim volume. In addition, many brachytherapy insertion codes have a minimal number of claims with a brachytherapy treatment delivery code on the same claim (i.e., CPT 19298, 20555, 43241, 58346). (See Table 2.)

Table 2: Claims With and Without Brachytherapy Treatment Delivery (2016 Claims Data)\*

HCPCS	CLAIMS		
	Total	No Brachytherapy Delivery	With Brachytherapy Delivery
19296	345	297	48
19298	54	45	*
19499	301	210	94
20555	*	*	*
31643	133	92	41
41019	72	60	12
43241	350	340	*
55875	3,553	1,029	2,524
55920	88	34	54
57155	1,586	553	1,033
58346	*	*	*

\*Same claims, claims with significant use of brachytherapy, split by presence of brachytherapy treatment delivery codes (CPT 77761-77763, 77770-77772, 77778, 0395T)

Based on additional data analysis from the Medicare 5% sample LDS SAF 2011-2015 pooled OPD and physician (carrier) files, we discovered that while some hospitals bill both the “J1” brachytherapy insertion code and the brachytherapy treatment delivery code on the same surgical claim, many others do not bill these services on the same claim. Typically, the “J1” brachytherapy insertion code is on the surgical claim and the related brachytherapy services are billed on another claim from another department in the same outpatient facility.

As part of an acceptable practice pattern, brachytherapy surgical insertion procedures may be provided in the outpatient setting but the brachytherapy treatment occurs at another site of service outside of the hospital setting (e.g., freestanding cancer center, ASC). This is common for the treatment of breast cancer and related breast brachytherapy catheter codes 19296 and 19298. Regarding CPT 19296, the breast catheter is always placed after a partial mastectomy, typically days after the surgical procedure. The catheter may be placed in the outpatient department or another site

of service such as a physician office. The patient may then receive brachytherapy treatment delivery at another site of service, including a hospital outpatient department, freestanding cancer center or ambulatory surgical center.

Given the complexity of coding, serial billing for cancer care, and potentially different sites of service for the initial surgical device insertion and subsequent brachytherapy treatment delivery, **AAPM opposes the proposed mandatory code edit for brachytherapy insertion procedures.**

Based on a legitimate process of care, a required code edit could not be applied to CPT 19296 and 19298. If the brachytherapy catheter insertion procedure (status indicator “J1”) is provided in the outpatient setting but brachytherapy treatment is provided in another site of service outside the hospital, then the outpatient department would not be able to provide a “correctly coded” claim and would not receive the Comprehensive APC payment for the brachytherapy insertion.

CMS should consider an alternative payment methodology for all brachytherapy insertion codes currently assigned status indicator “J1” and paid under the comprehensive APC methodology.

**AAPM recommends that CMS discontinue the Comprehensive APC payment policy for all brachytherapy insertion codes identified by CMS in the 2018 proposed rule.** CMS should revert to status indicator “T” for CPT codes 19296, 19298, 19499, 20555, 31643, 41019, 43241, 55920, 57155 and 58346.

Alternatively, CMS could continue to pay for “J1” brachytherapy insertion codes under the C-APC payment methodology but exclude all radiation oncology codes on the claim, defined as CPT codes 77261 through 77799, and make separate payment for the brachytherapy treatment delivery and related planning and preparation services in addition to the C-APC payment. This is similar to the modified Comprehensive APC policy for single session cranial stereotactic radiosurgery.

For Low Dose Rate Brachytherapy, **AAPM recommends that CMS continue the Composite APC payment methodology in 2018 for APC 8001 Low Dose Rate Prostate Brachytherapy Composite.** The current payment policy supports more accurate coding and packaging when the brachytherapy insertion code is provided on the same claim as the brachytherapy treatment delivery code (i.e. CPT 77778). CMS should revert to status indicator “Q3” for CPT code 55875.

#### ***A. List of Codes Described as Brachytherapy Insertion***

As noted above, CMS identifies a list “brachytherapy insertion codes” defined in Table 1. The AAPM has concerns regarding two (2) of the codes (CPT 43241 and 19499) because these codes are not used exclusively for brachytherapy but may be used for other radiation oncology related or non-radiation oncology related procedures. Only 3% of claims for CPT 43241 include a brachytherapy treatment delivery code.

- 43241 Esophagogastroduodenoscopy, flexible, transoral; with insertion of intraluminal tube catheter
- 19499 Unlisted procedure breast

**AAPM recommends that CMS remove CPT 43241 and 19499 from the list of brachytherapy insertion codes, as they are not used exclusively for brachytherapy treatment.**

**B. CPT 55875 Applies to Both Low Dose Rate and High Dose Rate Brachytherapy Treatment for Prostate Cancer**

In the proposed rule, CMS explicitly states that the required code edit for CPT 55875 *Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy* is brachytherapy treatment delivery code 77778 *Interstitial radiation source application, complex, includes supervision, handling, loading of radiation source, when performed*.

An outpatient claim with CPT 55875 and 77778 describes low dose rate prostate brachytherapy. High Dose Rate (HDR) brachytherapy is also used to treat prostate cancer. HDR brachytherapy treatment delivery codes are described by CPT 77770, 77771 and 77772. Table 3 below shows the units of brachytherapy treatment delivery codes associated with CPT 55875.

Table 3: Number of Brachytherapy Treatment Delivery Code Units on CPT 55875 Claims (2016 claims)

	<b>Total Claims</b>	<b>77770 HDR Claims</b>	<b>77771 HDR Claims</b>	<b>77772 HDR Claims</b>	<b>77778 LDR Claims</b>	<b>77790 Claims*</b>
CPT 55875	3,553	0	62	804	1,092	200

\*Not a brachytherapy treatment delivery code.

**C. Comprehensive APC Reassignment Based on CPT 55920**

CPT 55920 *Placement needles/catheters into pelvic organs and/or genitalia (except prostate) for radioelement application* is currently assigned to Comprehensive APC 5341 *Abdominal/ Peritoneal/ Biliary and Related Procedures* with a geometric mean cost of \$2,900.10. The geometric mean cost of CPT 55920 is \$4714.15.

Radiation therapy is an important adjuvant treatment for gynecological malignancies. The vignette for CPT 55920 describes a gynecological implant with a Syed-type intracavitary applicator insertion to the vagina, cervix, or female urethra. The applicator allows delivery of radioactive implants to a local tumor resulting in maximum dosage to tumor tissue, but limiting dosage to the surrounding normal tissue.

**If CMS maintains the Comprehensive APC payment policy for CPT 55920 in 2018, AAPM recommends that CPT 55920 be reassigned to the appropriate C-APC for Gynecologic Procedures (i.e. Level 1-6).** APC 5415 *Level 5 Gynecologic Procedures* has a geometric mean cost of \$4,084.23, which is more in line with geometric mean cost of CPT 55920 of \$4,714.15.

**D. Breast Brachytherapy Catheter Placement Payment Policy (CPT 19298)**

CMS continues to assign CPT 19298 *Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes image guidance* to Comprehensive APC 5092 *Level 2 Breast/Lymphatic Surgery and Related Procedures*. CPT 19298 describes the placement of multiple button and tube type catheters into the breast for brachytherapy treatment delivery at the time of or subsequent to partial mastectomy. The typical patient receives 10 fractions of brachytherapy over a 5-day period.

Historically, both breast brachytherapy catheter placement codes 19296 and 19298 were assigned to the same clinical and comprehensive APCs, as they are similar clinically and with regard to resource cost. Table 4 confirms that CPT 19296 and 19298 have similar geometric mean and median costs based on 2016 claims.

Table 4: Geometric Mean and Median Cost of Breast Brachytherapy Catheter Codes (2016 Claims Data)

HCPCS	SI	APC	Payment Rate	Single Frequency	Total Frequency	Median Cost	Geometric Mean Cost
19296	J1	5093	\$7,023.71	345	345	\$5,723.55	\$6,342.17
19298	J1	5092	\$4,616.48	53	54	\$5,547.24	\$5,450.85

The C-APC 5092 proposed payment of \$4,616.48 for CPT 19298 is less than what this procedure was paid under the traditional clinical APC prior to assignment to a comprehensive APC in 2015 (see Table 5 below). The current 2018 proposed payment is inaccurate and inappropriate and does not cover the costs associated with the surgical placement of the breast brachytherapy catheter, brachytherapy treatment delivery and all of the other related radiation oncology planning and preparation codes included on the claim.

Table 5: 2014-2018 APC Payment for Breast Brachytherapy Catheter Codes

HCPCS	Descriptor	2014 Clinical APC Payment	2015 C-APC Payment	2016 C-APC Payment	2017 C-APC Payment	2018 Proposed C-APC Payment
19296	Breast interstitial radiation treatment, delayed (expandable)	\$4,846.71	\$7,464.32	\$7,557.75	\$6,486.35	\$7,023.71
19298	Placement afterloading brachytherapy catheters (tube/button) into breast	\$4,846.71	\$7,464.32	\$7,557.75	\$4,419.46	\$4,616.48

**If CMS maintains the Comprehensive APC payment policy for CPT 19298 in 2018, the AAPM recommends that CMS reassign CPT 19298 Placement of radiotherapy afterloading brachytherapy catheters (multiple tube and button type) into the breast for interstitial radioelement application following (at the time of or subsequent to) partial mastectomy, includes image guidance to C-APC 5093 *Level 3 Breast/Lymphatic Surgery and Related Procedures*.**

## **2. Single Session Cranial Stereotactic Radiosurgery Payment Policy (CPT 77371 & 77372)**

In the 2018 proposed rule, CMS maintains CPT 77371 and 77372 single session cranial stereotactic radiosurgery (SRS) in Comprehensive APC 5627 *Level 7 Radiation Therapy*. The two SRS procedures included in C-APC 5627 must be in the same APC due to statute. These two procedures, while clinically similar, are not resource similar (see Table 6). Based on normal HOPPS configurations of APCs, these procedures would not generally be included within the same APC.

Table 6: C-APC 5627 (2016 claims)

<b>HCPCS</b>	<b>Single Frequency</b>	<b>Total Frequency</b>	<b>Geometric Mean Cost</b>
77371 SRS multisource Co-60	5,004	5,091	\$10,131.01
77372 SRS linac-based	4,354	4,371	\$5,398.98

In the 2016 HOPPS proposed rule, CMS recognized that the planning and preparation codes for SRS could be spread out over several days. This raised the problem of hospitals not being able to ensure that the set of codes related to the primary “J1” procedure could be captured in the C-APC methodology. CMS identified some, but not all, planning and preparation codes, and proposes continued separate payment in 2018 for the 10 codes listed below. We understand that CMS calculates the C-APC 5627 rate without including the cost associated with these codes.

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

In addition, the AAPM has previously commented that IMRT planning (CPT 77301) has become more common in single fraction radiosurgery treatment planning, and the omission from the list of planning and preparation codes subject to separate payment in 2016, 2017 and 2018 is inappropriate.

The data collection period for SRS claims with modifier “CP” began on January 1, 2016 and concludes on December 31, 2017. Based on analysis of preliminary data collected with modifier “CP” CMS has identified some additional services that are adjunctive to the primary SRS treatment and reported on a different claim outside of the 10 SRS planning and preparation codes that were removed from the SRS C-APC costs calculations and paid separately. However, CMS does not discuss the additional adjunctive services identified in the proposed rule. CMS notes that the “CP” modifier was used by a small number of providers and CMS analysis showed that several of the HCPCS codes that were billed with modifier “CP” belonged to the group of 10 SRS planning and preparation codes that CMS pays separately and do not require the use of modifier “CP”. CMS states that some providers erroneously included the modifier when reporting the HCPCS code for the delivery of the LINAC-based SRS treatment. Accordingly, for 2018, CMS is deleting the “CP” modifier and discontinuing its required use.

**AAPM supports continued separate payment for the ten (10) planning and preparation codes related to CPT 77371 and 77372. Further, we support the CMS proposal to discontinue use of “CP” modifier.**

We believe hospitals are not appropriately coding for SRS and stereotactic body radiation therapy (SBRT) services. CMS's continued separate payment for these services will not offer any solution within the C-APC methodology for how best to overcome the problem of this work being spread over several days, of related procedures falling on the same claim, or the prevention of hospitals splitting of claims (inadvertently or by design).

Also important to understand, is that the planning and preparation code sets are used in a wide range of radiation therapy procedures and are not, in themselves, identifiable to any one radiation therapy procedure.

Further, the C-APC methodology is also capturing costs for other therapeutic radiation oncology procedures, often delivered during the same time span as the SRS procedures, which treat different lesions (e.g., presence of SBRT procedures on same claims with SRS procedures). This reporting of two separate treatments areas during the same time span is not an uncommon clinical scenario. Handling of SBRT claims in rate setting for SRS distorts costs for the SRS C-APC and removes important SBRT data from rate setting for the SBRT APC.

**The current comprehensive APC methodology is not suited to single-session stereotactic radiosurgery (CPT 77371 and 77372).** The AAPM has long-standing concerns about this policy. The AAPM believes that the recent experience with bundling related to this comprehensive APC has been unnecessarily complex and clearly has caused both confusion and inaccuracy in coding for stereotactic radiosurgery procedures. The AAPM is concerned that the existence of a variety of claim durations and claim processes will continue to lead to incorrect coding and inconsistent reimbursement.

As CMS addresses more complex comprehensive APC configurations, the assumption that a patient is being treated in the outpatient hospital setting for a single problem represented on a single claim is not representative of complex oncology care. When complex interventions are introduced for patients with metastatic or other very severe/complex conditions, treatment for multiple conditions may be observed more often and spread out over several days or weeks. If rate setting always targets the average situation (e.g., single conditions treated on a claim), hospitals that treat the poorest and most seriously ill patients will not realize payment that captures their actual costs of care.

**AAPM urges CMS to eliminate the Comprehensive APC payment policy for single-session stereotactic radiosurgery code 77371 and 77372.** CMS should work with stakeholders to develop a more appropriate payment methodology for these services.

### **3. Comment Solicitation on Packaging of Items and Services Under the HOPPS**

CMS states that as the HOPPS continues to move towards a prospectively determined encounter-based payment and away from separate fee schedule-like payment, CMS continues to hear concerns from stakeholders that the packaging policies may be hampering patient access or resulting in other undesirable consequences. CMS notes that given that aggregate spending and utilization continue to increase for covered outpatient services, it is unclear what, if any, adverse effect packaging has on beneficiary access to care. CMS is interested in stakeholder feedback on common clinical scenarios involving currently packaged HCPCS codes for which stakeholders believe packaged payment is not appropriate under the HOPPS.



Since 2008, CMS has packaged image guidance procedures associated with radiation oncology services. This policy was not supported by the Advisory Panel on Hospital Outpatient Payment (HOP) based on their 2007 and 2008 recommendations to CMS.

AAPM remains concerned that the current packaging policy for image guidance may create an incentive for hospitals to cut back their use of advanced therapeutic technologies for daily patient localization used in radiation oncology treatment delivery in a way that could have a direct negative impact on the quality of patient care. The goal of radiation therapy is to maximize the radiation dose to the tumor site while minimizing the dose to surrounding healthy tissue. AAPM believes that the use of state-of-the-art radiation oncology treatment delivery modalities without the corresponding use of adequate daily target localization presents a serious safety risk to patients, and the current CMS policy seems to offer a financial incentive to those hospitals that choose to make little or no use of daily localization when providing radiation therapy. Image guidance procedures improve the quality of radiation treatment delivery and is not a significant additional cost to the Medicare program.

**AAPM recommends that the four (4) codes for image guidance procedures associated with radiation oncology services be exempt from the packaging policy. These include:**

- **76965 Ultrasonic guidance for interstitial radioelement application**
- **77014 Computed tomography guidance for placement of radiation therapy fields**
- **77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed**
- **77417 Therapeutic radiology port image(s)**

#### **4. Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

The Protecting Access to Medicare Act of 2014 establishes a program to promote the use of Appropriate Use Criteria (AUC) for advanced diagnostic imaging services. CMS is proposing that ordering professionals must consult specified applicable AUC through qualified clinical decision support mechanisms (CDSMs) for applicable imaging services furnished in an applicable setting, paid for under an applicable payment system and ordered on or after January 1, 2019. The Medicare AUC program is proposed to begin with an educational and operations testing year in 2019, which means physicians would be required to start using AUCs and reporting this information on their claims. During this first year, CMS is proposing to pay claims for advanced diagnostic imaging services regardless of whether they contain information on the required AUC consultation.

**AAPM supports the CMS proposal to implement the Appropriate Use Criteria (AUC) program on January 1, 2019. In addition, we support the one-year transition period where claims will be paid regardless of whether the correct information is provided on the claim.**

#### **5. Payment Adjustment Policy for Radioisotopes Derived from Non-Highly Enriched Uranium Sources**

CMS proposes to continue the policy of providing an additional \$10 payment for radioisotopes produced by non-highly enriched uranium (HEU).

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

## 6. ASC Payment Reform

In the 2018 proposed rule, CMS states that they are broadly interested in feedback, including recommendations and ideas for ASC payment system reform. CMS notes that average ASC payment rates have declined relative to HOPPS payments rates over the past 10 years, from 65 percent of average HOPPS rates in CY 2008 to 56 percent (as proposed) of average HOPPS rates in CY 2018.

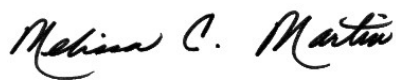
Currently, ASC payments are annually updated for inflation by the percentage increase in the Consumer Price Index for all urban consumers (CPI-U). In this proposed rule, CMS is soliciting comment on the ASC payment system update factor and is interested in data from ASCs that would help determine whether the ASC payment system should continue to be updated by the CPI-U, or by an alternative update factor, such as the hospital market basket, the Medicare Economic Index, a blend of update factors or other mechanism.

The current ASC payment system aligns ASC rates with the ambulatory payment classification (APC) groups that are used to pay for services in hospital outpatient departments. CMS updates the ASC relative payment weights each year using the Hospital Outpatient Prospective Payment System (HOPPS) relative payment weights (and Medicare Physician Fee Schedule nonfacility practice expense relative value based amounts, as applicable) for that same calendar year and uniformly scale the ASC relative payment weights for each update year to make them budget neutral. CMS bases the HOPPS relative payment weights on geometric mean costs, therefore, the ASC system also uses geometric means to determine relative payment weights under the ASC standard rate setting methodology.

**Given that the ASC payment system is based on the same principles as the HOPPS, AAPM recommends that CMS utilize the same annual update factor as the HOPPS, which is the hospital market basket.**

We hope that CMS will consider these issues during the development of the 2018 HOPPS final rule. Should CMS staff have additional questions, please contact Wendy Smith Fuss, MPH at (561) 637-6060.

Sincerely,



Melissa Carol Martin, MS, FAAPM, FACMP, FACR  
President, AAPM



Blake Dirksen, M.S.  
Chair, Professional Economics Committee



Jonas Fontenot, Ph.D.  
Vice-Chair, Professional Economics Committee